FINAL REPORT
OF THE
TASK FORCE TO REVIEW PRIMARY HEALTH CARE

Ministry of Health
Ontario
Ministère de la Santé

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December 30, 1982

Rt. Hon. Larry Grossman, Q.C.
Minister's Office
Ministry of Health
10th Floor, Hepburn Block
80 Grosvenor Street
TORONTO M7A 1R3
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Dear Mr. Minister,

It is my pleasure to submit to you the Report of the Task Force to Review Primary Care.

It is the hope of the Task Force that this Report will be of use to your Ministry in the development of policies to facilitate the planning and delivery of primary health care services, in both the short and long term, for the population of Ontario.

Yours sincerely,

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REPORT OF THE TASK FORCE TO REVIEW PRIMARY HEALTH CARE

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SUMMARY OF RECOMMENDATIONS

I. GENERAL

1. IT IS IMPORTANT THAT THE POLICIES OF THE GOVERNMENT OF ONTARIO WITH REGARD TO ITS SUPPORT FOR HEALTH SERVICES BE SUCH THAT THEY ALLOW FOR THE DEVELOPMENT OF A VARIETY OF ARRANGEMENTS FOR THE PROVISION OF PRIMARY HEALTH CARE IN ONTARIO.

2. SINCE THE DEVELOPMENT OF HEALTH SERVICE ORGANIZATIONS AND HEALTH CENTRES HAS BEEN IN PART A RESPONSE OF PROVIDERS AND CONSUMERS TO SPECIAL NEEDS IN THE PROVISION OF HEALTH SERVICES, WE RECOMMEND THAT THESE DEVELOPMENTS BE ACCEPTED AS TWO LEGITIMATE FUNDING MODELS FOR THE PROVISION OF PRIMARY HEALTH SERVICES IN THE COMMUNITY.

II. FUNDING

1. RECOMMENDATIONS REGARDING HEALTH SERVICE ORGANIZATION (CAPITATION) FUNDING:

    a) HEALTH SERVICE ORGANIZATIONS ON THE CAPITATION-NEGATION FUNDING MECHANISM SHOULD CONTINUE TO BE SUPPORTED BY THE MINISTRY SIMULTANEOUSLY WITH FEE-FOR-SERVICE PAYMENT AS A FULLY DEVELOPED MODEL FOR PRIMARY CARE WITHIN A PLURALISTIC SYSTEM.

b) THE MINISTRY, IN COOPERATION WITH THE MEDICAL PROFESSION, INFORM HEALTH CARE CONSUMERS AND PROVIDERS ABOUT THE GOALS AND OBJECTIVES OF HEALTH SERVICE ORGANIZATIONS.

c) THE MINISTRY FACILITATE THE DEVELOPMENT OF NEW HEALTH SERVICE ORGANIZATIONS.

d) THE CURRENT CAPITATION FORMULA USED BY THE MINISTRY SHOULD BE MODIFIED TO PAY HEALTH SERVICE ORGANIZATIONS ON THE BASIS OF THEIR TOTAL ROSTER INCLUDING BOTH ELIGIBLE AND INELIGIBLE ENROLLEES RATHER THAN ONLY THEIR OHIP ELIGIBLE ROSTER.

2. RECOMMENDATIONS REGARDING HEALTH CENTRES (GLOBAL) FUNDING:

a) HEALTH CENTRES CURRENTLY SUPPORTED BY THE MINISTRY ON A GLOBAL FUNDING FORMULA SHOULD CONTINUE.

b) THE BASIS OF HEALTH CENTRE FUNDING SHOULD BE A NEGOTIATED PROGRAM BUDGET RELATED TO THE REQUIREMENTS OF THE PROGRAM OPERATION AT THE HEALTH CENTRE AND THE NEEDS OF THE POPULATION BEING SERVED.

c) GLOBAL FUNDING FOR HEALTH CENTRES SHOULD BE VIEWED AS A LEGITIMATE FUNDING MECHANISM FOR THESE DISTINCT PRIMARY CARE AGENCIES AND NOT AS AN INTERIM ARRANGEMENT FOR FUTURE CAPITATION FUNDING AS HEALTH SERVICE ORGANIZATIONS.

d) THE MINISTRY OF HEALTH, IN COOPERATION WITH THE MEDICAL PROFESSION, INFORM HEALTH CARE CONSUMERS AND PROVIDERS ABOUT THE GOALS AND OBJECTIVES OF HEALTH CENTRES.

e) THE MINISTRY SHOULD RECOGNIZE THE NEED AND PROVIDE ADDITIONAL FUNDING FOR THE SPECIAL ADMINISTRATIVE BURDEN INVOLVED IN OPERATING A COMMUNITY HEALTH CENTRE.

3. RECOMMENDATIONS REGARDING THE AMBULATORY CARE INCENTIVE PROGRAM:

a) ACIP SHOULD BE RECOGNIZED AS AN EFFECTIVE INCENTIVE TO PRIMARY CARE AGENCIES TO REDUCE HOSPITALIZATION AND SHOULD BE EXTENDED TO ALL PRACTICES THAT ARE WILLING TO MEET THE CRITERIA FOR ROSTERING THEIR PATIENTS.

b) THE CONCEPT OF THE ACIP SYSTEM SHOULD BE CONSIDERED FOR EXTENSION TO OTHER ASPECTS OF INSTITUTIONAL SERVICES.

c) THE MINISTRY SHOULD CONTINUE TO REFINE THE ACIP SYSTEM.

4. ALL PRIMARY CARE DELIVERY ARRANGEMENTS, FROM SOLO PRACTITIONERS TO COMMUNITY HEALTH CENTRES, SHOULD HAVE AVAILABLE TO THEM APPROPRIATE FUNDING MECHANISMS OR A MIX OF MECHANISMS CAPABLE OF MEETING THE NEEDS OF PROVIDERS AND CONSUMERS, IF APPROPRIATE CRITERIA ARE MET:

   a) THE MINISTRY SHOULD ESTABLISH AS THREE SEPARATE FUNDING PROGRAMS:
      i. OHIP FEE-FOR-SERVICE
      ii. CAPITATION-NEGATION
      iii. PROGRAM BUDGET.

   b) CRITERIA SHOULD BE SPECIFIED FOR PARTICIPATION IN EACH OF THE THREE PROGRAMS.

   c) DELIVERY AGENCIES SHOULD BE ALLOWED TO PARTICIPATE IN ONE OR ANY APPROPRIATE COMBINATION OF PROGRAMS.

   d) PROGRAM BUDGETS SHOULD BE AVAILABLE TO FUND AN ENTIRE OPERATION (AS IN A COMMUNITY HEALTH CENTRE) OR A PROGRAM COMPONENT (AS IN A FEE-FOR-SERVICE PRACTICE).

III. RECOMMENDATIONS REGARDING ESTABLISHING NEW HEALTH CENTRES

1. WHERE A COMMUNITY GROUP WISHES TO ESTABLISH A NEW HEALTH CENTRE REQUIRING A GLOBAL BUDGET, IT SHOULD BE WITH THE ENDORSEMENT OF A BROADLY BASED COMMUNITY GROUP. IN SOME AREAS, WHERE THE DISTRICT HEALTH COUNCILS HAVE ESTABLISHED WITH LOCAL GROUPS EFFECTIVE PLANNING ARRANGEMENTS FOR LOCAL CARE, THEY WOULD BE THE MOST APPROPRIATE GROUP FOR DOING THIS. IN OTHER AREAS, PUBLIC HEALTH UNITS, REGIONAL GOVERNMENT, HOSPITALS, OR OTHER COMMUNITY-BASED ORGANIZATIONS MAY BE THE COMMUNITY ENDORSER.

2. THE ESTABLISHMENT OF A MAJOR NEW PROGRAM SHOULD BE DEPENDENT ON MEETING THE FOLLOWING CRITERIA WITHIN THE CONTEXT OF THE SERVICES ALREADY IN THE COMMUNITY:

   a) THERE IS CLEAR COMMUNITY SUPPORT FOR THE GROUP

   b) THERE IS CLEAR INDICATION OF NEED OR DEMAND BY THE POPULATION TO BE SERVED

   c) THERE IS A CLEAR DESCRIPTION OF THE POPULATION TO BE SERVED

d) THERE IS A CLEARLY DEFINED PROGRAM THAT WILL MEET THE NEEDS OF THE TARGET POPULATION

e) THERE IS A PROCEDURE ESTABLISHED TO EVALUATE THE OBJECTIVES OF THE PROGRAM.

IV. RECOMMENDATIONS REGARDING PLANNING AND PRIORITIES

1. THE MINISTRY OF HEALTH SHOULD GIVE A HIGH PRIORITY TO THE OVERALL PLANNING FOR "PRIMARY HEALTH CARE SERVICES", AS THE TERM IS DEFINED IN THIS REPORT. FURTHER, THE MINISTRY OF HEALTH SHOULD TAKE A "LEAD" ROLE IN FACILITATING CO-ORDINATION BETWEEN ITSELF AND THE OTHER APPROPRIATE MINISTRIES REGARDING THE PLANNING OF OTHER HEALTH-RELATED SERVICES WHICH IMPINGE UPON PRIMARY HEALTH CARE.

2. THE MINISTRY OF HEALTH, THROUGH DISTRICT HEALTH COUNCILS OR OTHER APPROPRIATE AGENCIES, ESTABLISH WITH LOCAL GROUPS, PLANNING ARRANGEMENTS FOR THE DEVELOPMENT OF PRIMARY HEALTH CARE SERVICES TO MEET THE NEEDS OF THE VARIOUS POPULATION GROUPS IN THE COMMUNITY.

   DISTRICT HEALTH COUNCILS ARE ONE POTENTIAL VEHICLE FOR DOING THIS.

IF DISTRICT HEALTH COUNCILS ARE TO TAKE ON THIS ROLE IT IS IMPORTANT THAT THEY HAVE THE APPROPRIATE RESOURCES TO CARRY OUT THE TASK.

IN LARGE METROPOLITAN AREAS, IT IS IMPORTANT THAT THE PLANNING ARRANGEMENTS UNDER DISTRICT HEALTH COUNCILS BE SUITABLY MODIFIED AND DECENTRALIZED TO MEET THE LOCAL NEEDS OF A COMPLEX METROPOLITAN AREA.

3. THE DEVELOPMENT OF COMMUNITY HEALTH CENTRES SHOULD, IF AT ALL POSSIBLE, COME UNDER THE UMBRELLA OF THE DISTRICT HEALTH COUNCILS, BOTH IN TERMS OF TAKING PART IN THE PLANNING FOR COMMUNITY HEALTH SERVICES AND THE DEVELOPMENT OF NEW COMMUNITY HEALTH CENTRES. DISTRICT HEALTH COUNCILS COULD, IN FACT, BE ONE OF THE MECHANISMS FOR ESTABLISHING NEW COMMUNITY HEALTH CENTRES.

4. THE MINISTRY OF HEALTH SHOULD ESTABLISH, IN COLLABORATION WITH DISTRICT HEALTH COUNCILS, A DATA BASE DESCRIBING THE HEALTH STATUS OF THE POPULATION OF ONTARIO BY HEALTH COUNCIL DISTRICT. IT SHOULD ALSO ESTABLISH MECHANISMS FOR IDENTIFYING HOW THE POPULATIONS AT RISK VIEW THE VARIOUS HEALTH

SERVICE ARRANGEMENTS. THIS IS IMPORTANT FOR LONG-TERM PLANNING AND THE ESTABLISHMENT OF PRIORITIES.

FURTHER, THE MINISTRY OF HEALTH OR THE GOVERNMENT OF ONTARIO SHOULD ASK THE FEDERAL GOVERNMENT WHEN DOING ITS PERIODIC HEALTH SURVEYS TO DO SO IN A MANNER THAT WILL ENHANCE THE DATA BASE FOR ONTARIO.

5. THE MINISTRY OF HEALTH, THROUGH ITS DISTRICT HEALTH COUNCILS AND PUBLIC HEALTH UNITS, SHOULD DEVELOP LOCAL ARRANGEMENTS FOR PLANNING BASED ON THE HEALTH STATUS OF THE POPULATION AND ITS USE OF HEALTH SERVICES.

6. THE FACULTIES IN THE HEALTH SCIENCES SHOULD WORK WITH THEIR LOCAL COMMUNITIES IN DEVELOPING COMBINED ACADEMIC AND SERVICE UNITS, WHERE APPROPRIATE, FOR THE PREPARATION OF HEALTH PROFESSIONALS FOR CAREERS IN PRIMARY CARE AND INITIATING THE APPROPRIATE COMMUNITY BASED HEALTH RESEARCH NECESSARY FOR THE EFFECTIVE UNDERSTANDING AND MANAGEMENT OF COMMUNITY HEALTH PROBLEMS.

7. THE PROGRAMS THAT HAVE BEEN DEVELOPED BY THE PROVINCE ALLOWING FOR THE INVOLVEMENT OF FACULTIES OF HEALTH SCIENCES WITH COMMUNITY GROUPS IN APPLIED AND OPERATIONAL HEALTH RESEARCH SHOULD BE PROVIDED THE NECESSARY SUPPORT TO ENSURE THAT THIS ARRANGEMENT IS EXTENDED TO ALL PARTS OF THE PROVINCE.

V. RECOMMENDATIONS REGARDING CONSUMER NEEDS AND EQUITY

1. THE DISTRICT HEALTH COUNCIL, IN COLLABORATION WITH LOCAL PRIMARY CARE GROUPS, SHOULD ENSURE THAT THE LOCAL COMMUNITY IS AWARE OF THE VARIOUS HEALTH SERVICES AVAILABLE AND HOW TO ACCESS THEM.

2. THE DISTRICT HEALTH COUNCIL, TOGETHER WITH THE COMMUNITY INVOLVED, SHOULD BE ABLE TO IDENTIFY POPULATIONS AT RISK AND THEIR ABILITY TO ACCESS EXISTING HEALTH SERVICES.

3. THE DISTRICT HEALTH COUNCILS, WORKING WITH APPROPRIATE CONSUMER GROUPS SHOULD PLAN FOR THE DEVELOPMENT OF PRIMARY CARE SERVICES TO MEET THE NEEDS OF PARTICULAR POPULATION GROUPS.

VI. RECOMMENDATION REGARDING ASSESSMENT AND EVALUATION

IN THE LONG-TERM, IT IS IMPORTANT THAT CONSIDERATION BE GIVEN TO DEVELOPING ASSESSMENT

AND EVALUATION PROCEDURES FOR EVALUATING THE OVERALL PERFORMANCE OF PRIMARY HEALTH CARE SERVICES.

VII. RECOMMENDATIONS REGARDING PROFESSIONAL STANDARDS, TRAINING AND ACCREDITATION

1. THAT THE CONCEPT OF ACCREDITATION, PEER REVIEW OF PROFESSIONALS AND THE DEVELOPMENT OF STANDARDS SHOULD BE EXTENDED TO ALL PRIMARY CARE SERVICES.

2. THAT THE MINISTRY OF HEALTH AND THE ASSOCIATION OF ONTARIO HEALTH CENTRES SHOULD WORK TOGETHER TO DEVELOP STANDARDS AND MECHANISMS FOR ACCREDITATION AND ACCOUNTABILITY FOR HEALTH SERVICE ORGANIZATIONS AND HEALTH CENTRES IN ONTARIO.

3. EDUCATIONAL PROGRAMS FOR PROFESSIONALS (E.G. PHYSICIANS AND NURSES) IN PRIMARY HEALTH CARE SHOULD BE ENCOURAGED TO DEVELOP COMMON EDUCATIONAL OBJECTIVES IN CLINICAL SETTINGS WHERE JOINT RESPONSIBILITY FOR THE PROVISION OF CARE CAN BE WORKED OUT.

4. WHERE CLINICAL EXPERIENCE IN A SERVICE DELIVERY SETTING IS DESIRABLE FOR THE PREPARATION OF HEALTH PROFESSIONALS IN PRIMARY CARE (FOR EXAMPLE, NURSES, SOCIAL WORKERS), IT IS

RECOMMENDED THAT THE GOVERNMENT PROVIDE THE FUNDING ARRANGEMENTS FOR ALL HEALTH PROFESSIONALS, USING THE SAME PRINCIPLES THAT HAVE BEEN DEVELOPED FOR THE SUPPORT OF PHYSICIANS TRAINING IN THE PRIMARY CARE SETTING.

5. IN ORDER TO FACILITATE STUDENTS BEING AWARE OF DIVERSE ARRANGEMENTS FOR THE PROVISION OF PRIMARY CARE SERVICES, THE MINISTRY OF HEALTH, THROUGH ITS FUNDING ARRANGEMENTS, SHOULD ENCOURAGE UNIVERSITIES AND COMMUNITY COLLEGES TO PROVIDE OPPORTUNITIES FOR STUDENTS TO SECURE SOME OF THEIR CLINICAL EXPERIENCE IN DIFFERENT KINDS OF PRIMARY CARE SETTINGS, INCLUDING HEALTH CENTRES AND HEALTH SERVICE ORGANIZATIONS.

6. RESTRICTIVE CLAUSES IN HEALTH PROFESSIONAL LEGISLATION AND REGULATIONS BE REVIEWED PERIODICALLY WITH CONSIDERATION GIVEN TO REDUCING INEFFICIENCY WHILE STILL PROTECTING THE PUBLIC.

VIII. LONG-TERM DEVELOPMENTS

THAT THE MINISTRY OF HEALTH ESTABLISH A TASK GROUP WITH THE LONG-TERM RESPONSIBILITY OF CONDUCTING A MUCH MORE IN-DEPTH REVIEW OF THE WHOLE PRIMARY CARE SECTOR. THIS TASK GROUP'S DELIBERATIONS SHOULD INCLUDE THE FOLLOWING: INCENTIVES FOR EFFICIENCY;

DECENTRALIZATION; INTEGRATION OF PRIMARY AND SECONDARY CARE SERVICES; A DATA BASE ON HEALTH STATUS AND, THE BEST MIX OF PROFESSIONALS. THE TASK FORCE SHOULD BRING FORTH RECOMMENDATIONS FOR THE LONG-TERM DEVELOPMENT OF THE PRIMARY CARE SECTOR WITHIN THE CONTEXT OF THE ENTIRE HEALTH CARE SYSTEM.

TASK FORCE TO REVIEW THE PRIMARY HEALTH CARE SECTOR

CHAPTER 1

1.1 INTRODUCTION

In Canada, the Governments have assumed responsibility for funding the delivery of Health Care services and for the broad policies within which services are provided. The basis for much of the philosophy and policies under which our Health Care services are provided is reflected in the Health Charter for Canadians set out in the report of the Royal Commission on Health Services[1]:

> "The achievement of the highest possible health standards for all our people must become a primary objective of national policy and a cohesive factor contributing to national unity, involving individual and community responsibilities and actions. This objective can best be achieved through a comprehensive universal health services program for the Canadian people."

Since the Governments have assumed the responsibility for funding Health Care services, they also find themselves under pressure to define Health Care needs in terms of broad societal goals, including social equity. They obviously have to try to match the financial resources to meet the Health Care needs they are prepared to fund within their broad policy objectives. Given the nature of the Canadian Federation, there are two further complications:

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[1] Report of the Royal Commission on Health Services (Hall Report), Ottawa, Queen's Printer, 1964.

i) determining how the revenue requirements will be met and shared between the Federal and Provincial Governments, and

ii) whether the provinces meet the Federal objectives set for the Federal portion of the funding.

The Health Charter indicated the importance of public funding of health care, to achieve broad national objectives. However, the conflicts between Federal-Provincial Governments about costs and the problem of matching needs and revenues have yet to be resolved.

The Ontario Health Care system today results, in large measure, from the work of the Hall Commission whose report led to full public funding for health care services in Canada. The Commission estimated, quite correctly, that removal of the financial barriers which prevented access to health care would increase utilization of health care services. In turn, this would produce a need for expanded facilities and greater numbers of health care personnel to meet the increased utilization. The Commission projected that by 1980, Canada could be devoting as much as 7% of its gross domestic expenditure* to health care services and it would require a substantial increase in numbers of physicians. Canada has largely met these targets set in 1964. Given this record of achievement of broadly adopted national goals, it may appear surprising that there is so much concern today about how we are providing health care services and their cost.

Among the factors that appear to have contributed to this concern are: the continuing increase in physician supply, pressures to increase health care expenditures, changing priorities in public spending and recognition that some of the major determinants of health are not always influenced by health care services.

Current problems centre around two major focal points: namely, (1) cost; and (2) the allocation of adequate health care resources to meet the demands of the population. In examining both these issues, one of the common and key elements is the effectiveness with which health care services are delivered[2] and, as this report will identify, the efficiency of all health care services is heavily dependent on the effectiveness of the Primary Care Sector. We will examine the developments in Primary Health Care services in Ontario and some of their implications for the future, with particular reference to current arrangements for providing community health services, often referred to administratively, as Health Service Organizations and Health Centres.

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*This was the measure of national wealth used by the Hall Commission in place of the more widely used Gross National Product

[2] Enthoven, A.C., Health Plan, Addison Wesley, Reading, Mass, 1980.

The Growth in Health Care Cost and the Impact of Fiscal Constraints

In Ontario the rapid growth in health care expenditures occurred in the decades of the 1950's and 1960's. Bird[3] has stated that in the period between 1954 and 1965 health care expenditures accounted for 34% of the total growth of governmental expenditures taken as a share of Canada's gross national expenditure. From 1965 to 1970 the comparable figure was 27%. In the period since 1971, however, very little growth has occurred. For example, during the period from 1976-77 to 1981-82 Ontario's expenditure on institutional health care, expressed as a percentage of the Gross Provincial Product fell from 3.14% to 2.83%. However, during this period the cost of physicians' services increased from 0.93% to 1.03% of the Gross Provincial Product[4]. Also part of the changing patterns is the introduction of new but much more expensive technology. Canadians may now receive a larger package of public health services than before the introduction of government funding, but in "constant dollar" terms, the amount spent on health care has decreased.

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[3] Bird, R.M. and Fraser, R.D., Commentaries on the Hall Report, Ontario Economic Council, Toronto, 1981.

Governments have sought to contain further increase in health care expenditures by limiting the amount of money available. They have done this primarily by setting budget limits and, as a consequence, containing hospital expenditures and physician incomes. If the constraints become too severe, a number of developments can occur:

a) the government-established budget limits may be breached by institutions, i.e. hospitals continue to provide service at former levels when funding is inadequate to maintain these levels. This creates pressure on the government to pick up the deficit. If the government does not pick up this deficit, the institutions begin to restrict access to services or to levy additional charges for them;

b) unrest may grow among the professionals, who perceive their incomes to be unduly constrained, or among consumers, who are unable to obtain immediate access to the desired services. Dissatisfaction among professional groups can lead to work disruption, to loss of substantial numbers who leave to practise their profession in another jurisdiction; and to increased opting out by physicians;

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[4] Report of the Task Force on Medical Manpower: Council of Ontario Universities, Toronto, August 1982, p.19.

c) a decline in the quality and the availability of publicly funded health care services can lead to the evolution of two standards of health care: a higher cost, private system for those who can afford it and a lower cost one for those dependent upon the publicly funded system.

It is not known what effects, if any, the fiscal constraints have had or may have on the quality of health care services in Ontario. But pressures clearly exist for changes to take place in the health care system. A key question is, of course, what kind of changes will occur? Changes could occur that would largely negate the Health Charter for Canadians set out in the Royal Commission on Health Services. However, it is also possible that changes could occur which would lead to a more efficient health care system and still maintain the basic principles of the Charter. There is, therefore, interest in arrangements that could make the publicly-funded health services more efficient.

Health and Health Care Services

It is generally assumed that there is a close link between the health of the population and accessibility to quality health care services. The better the health care system, the better the overall health status of the population. This simple relationship, however, has been questioned by recent reports. Using indicators such as mortality, a number of studies in developed countries have shown that there is no significant correlation between the health status of the population and overall expenditures on health care. As McKeown[5] has demonstrated, improvements in human health in western countries over the past 100 years or so, as measured by life expectancy, have been primarily due to factors other than health care services. As he demonstrated, the major gains in life expectancy over the last 150 years in the United Kingdom are largely the result of improved nutrition, better water and sewage systems and reduced family size. The dramatic reduction in mortality from infectious diseases occurred long before we had effective medical interventions to control these disorders. As recognition has increased that health care is only one of the factors affecting the health status of populations and a minor one in terms of life expectancy, some physicians and social scientists are questioning the level of public expenditures on health care. In the United Kingdom this problem has been reviewed in considerable depth by a committee chaired by Sir Douglas Black. In the report entitled "Report on Inequalities in Health"[6] they show that, despite a comprehensive national health care system that has been in place for more than 30 years, and despite an overall improvement in life expectancy, the difference in life expectancy between individuals in Social Classes IV and V compared to those in Social Classes I and II had actually increased. (Social Classes I and II are in professional and managerial occupations; Social Classes IV and V are in semi-skilled and unskilled occupations.) They concluded that the major factor causing this inequality in health as measured by mortality and morbidity data appeared to be socio-economic factors, not lack of health care services or financial barriers to access. It was also pointed out that the individuals who tended to have the greatest burden of ill health, that is, those of the lower social economic classes, were the least effective users of the health care system in relation to their burden of illness.

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[5] McKeown, T., The Modern Rise of Population. Edward Arnold, Publisher, London, 1976.

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[6] "Inequalities in Health", Report of a Research Working Group (Chairman: D. Black), Department of Health and Social Services- London, Her Majesty's Stationary Office, 1980. An edited version of this Report is also available, see: Townsend, P. and Davidson, N. (eds), Inequalities in Health: The Black Report, Penguin Books, Harmondsworth, England, 1982.

Recent Canadian studies[7,8] have also demonstrated a relationship between social and economic factors, and health. In a study by the Institute for Research on Public Policy, it was demonstrated that the life expectancy of individuals living in the poorest district of Montreal was more than seven years less than that of the population living in the most affluent districts of the same city[7]. Life expectancy by district was found to be related to income, education and occupation. There was no evidence of any decline in the higher mortality rate in the disadvantaged districts over a 15-year period (1961-1976). A recent report by Health and Welfare Canada[8] presents similar information about the relationship between income level and life expectancy. Some of these studies demonstrate that the lower the income and educational levels are, the higher the mortality rate will be.

More specifically, the recently completed Canada Health Survey[9] illustrates a significantly greater burden of illness among the poor and less educated compared to the non-poor and better educated as measured by:

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[7] Wilkins, R. "Health Status in Canada 1926-1976". Institute for Research on Public Policy, Occasional Paper No. 13, Montreal, 1980.

[8] Mortality by Income Level in Urban Canada. Health and Welfare Canada, Queen's Printer, 1980.

[9] The Health of Canadians: Report of the Canada Health Survey. Statistics Canada, Catalogue No. 82-538E, Ottawa, Ministry of Supply and Services Canada, 1981.

1) disability days;
2) symptoms of anxiety and depression; and
3) self-reported morbidity for 14 out of 21 illness categories.

Paradoxically, self-reported consultations with a health professional did not differ between the poor and non-poor.

Thus, on the one hand there is evidence which indicates a shorter life expectancy and higher illness burden among poor and less educated Canadians. On the other hand evidence also suggests that consultations with health professionals are no different. This may mean that the poorer socio-economic classes make less use of health care services in relation to their illness burden than more affluent groups.

In the "Inequalities in Health" report[10], the competing demands for scarce resources for solving health problems is brought out. The committee, which was composed of two social scientists and two physicians, was split over how the government should find the funds to redress the inequalities in health. Half the Committee (the two social scientists) felt that the most appropriate route to find the necessary resources would be to reduce expenditure on health care services and transfer these funds to programmes targeted at modifying the social and economic factors that contribute to inequalities in health. The two physicians on the committee could not support this, because they recognized that although health care services were not the primary factor influencing life expectancy, they were very important for care of individuals when they were ill and played a major role in influencing their quality of life. They felt that reduction of expenditures on health care services would exacerbate the inequalities in health.

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[10] "Inequalities in Health", Report of a Research Working Group (Chairman: D. Black), Department of Health and Social Services- London, Her Majesty's Stationary Office, 1980. An edited version of this Report is also available, see: Townsend, P. and Davidson, N. (eds), Inequalities in Health: The Black Report, Penguin Books, Harmondsworth, England, 1982.

Public funding of health care services contributes to reducing inequalities in health. Recent analyses of the impact of Medicaid and Medicare programs on the U.S. population indicate that these programs have influenced the quality of life for the poorer classes and the elderly; they have also contributed significantly to improved life expectancy for this population[11,12]. Thus, although health care services are not the primary determinant of health, their influence on the quality of human life, and their impact on the life expectancy of the less affluent members of society emphasizes the importance of making quality health services available and financially accessible to all members of the population.

Health Care Services and Health Care Needs

Changes in the demography of populations brought about by the reduced birth rate and improved life expectancy have a considerable influence on the needs of the population for health care services. One method of assessing the needs for health care services is to estimate the capacity of the system to provide supportive care for the population, an increasing proportion of whose members will be gradually losing the vitality of key organ systems as they approach the limits of human life expectancy (what Fries and Crapo describe as a "biological wall)"[13]. The impact of

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[11] Rogers, D.E., Blendon, R.J. and Moloney, T.W., Who Needs Medicaid? New England Journal of Medicine, 307, 1, 13-18, July, 1982.

[12] Special Report: Report on the Duke University Medical Center Private Sector Conference. New England Journal of Medicine, 307, 1, 68-71, July, 1982.

[13] Fries, J. F. and Crapo, L. M., Vitality and Aging. W. H. Freeman and Company, San Fransisco, 1981.

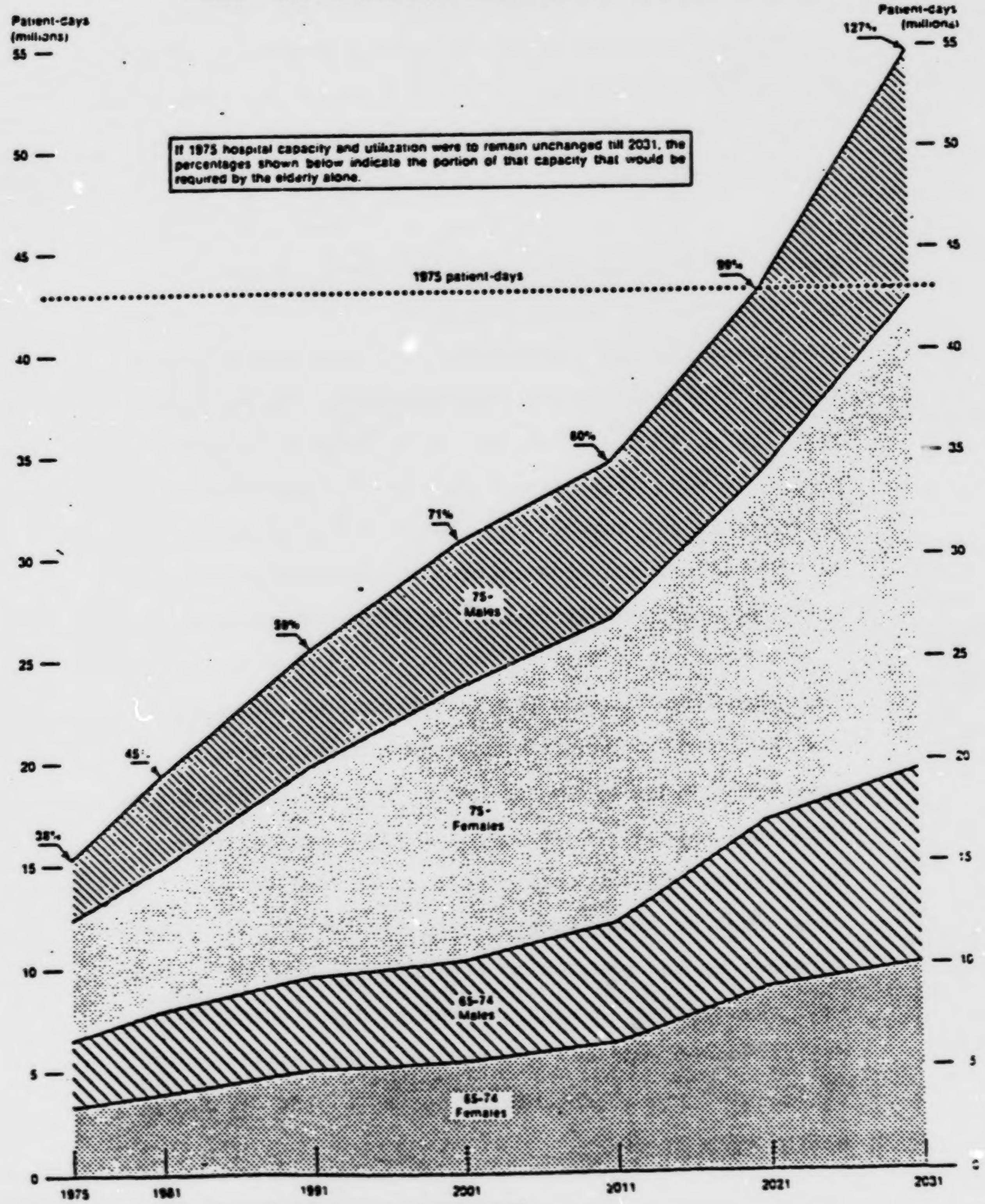
changing health care needs becomes apparent when examining the effect of an increasing proportion of the population over the age of 65 on health care costs. Figure I projects this impact on the current hospital capacity in Canada.

The introduction of more effective measures for preventing or postponing the onset of chronic disorders that cause premature disability or death will continue to have a marked impact on health care. It is anticipated that the "market share" of health service concerned with this form of prevention, and the maintenance and support of individuals with chronic disorders will continue to grow at the expense of those services concerned with acute crisis interventions.

The population's needs for health care services should also be a determinant of the health care system. However, the definition of needs is not easy and varies with the perspective of the individual making the definition. Health care needs, as defined by government or professionals, and the demands for these services by the population are often in conflict. How well the consumer demand and the funder or provider definition of need are matched will determine, ultimately, the acceptability to the public of the health care system.

FIGURE I

PATIENT DAYS REQUIRED BY ELDERLY, 1975 to 2031*



If 1975 hospital capacity and utilization were to remain unchanged till 2031, the percentages shown below indicate the portion of that capacity that would be required by the elderly alone.

*Source: A Prognosis for Hospitals: the effects of population change on the need for hospital space, 1967-2031, Cat. 83-520E, Statistics Canada, 1980

Accessibility, Effectiveness and Efficiency in Health Care Services

The accessibility question is complex. In some jurisdictions there is evidence that, with publicly funded health care, the poorer classes do not use health care services to the same extent, considering their burden of illness, as do the more affluent. A recent study by National Health and Welfare has indicated that the volume of care consumed tends to be greater by families with lower incomes, although the data did not indicate how this care related to the medical needs of the population at risk[14]. The authors concluded that an analysis of the supply of physicians in relation to the medical needs of the population at risk would probably document the need to implement policies designed to achieve a more equitable geographical distribution of medical personnel. In another study of the changes that occurred in health care utilization in Montreal, before and after the public funding of health care, it was documented that there was a shift in use from higher to lower income groups, demonstrating greater accessibility with the removal of financial barriers to health services[15].

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[14] Broyles, W., Manga, P., Binder. D., Angus. D. and Charette, A. The use of physicians' services under a national Health Insurance program: An examination of the Canada Health Survey. Medical Care (in press).

Accessibility to services is not assured by the removal of financial barriers. Language or cultural barriers may exist for certain ethnic groups, for example, by virtue of the place in which services are made available or the relationship between professionals and patients. Health services need to be accessible and acceptable to the populations for whom they are intended if they are to be used and thus, effective. Financial access or physical availability is not sufficient alone.

Anticipating health care demand based on needs is difficult because it can be influenced by so many factors. For example, ethnic groups that may not have large incomes may nevertheless have personal (family) support systems that minimize their demands on health and social services. In contrast, single individuals (for example, single mothers with low income) may have little support other than that provided by health and social services. Until such time as detailed studies can be conducted concerning the burden of illness across population groups, and cultural as well as economic factors are taken into account, we will not really have a clear picture of how well health services are meeting the needs of our heterogeneous population, particularly in urban areas.

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[15] Enterline, Philip E., et al. "The distribution of medical services before and after "free" medical care - the Quebec experience", The New England Journal of Medicine, 289 (22): 1174-1178, November, 1973.

There is some concern in Ontario that certain population groups need to have the full, integrated support of health and social services to maintain them as effective members of society. Certain Health Centres* have been in the forefront of those articulating this perception of need for special groups in society. Unfortunately, a provincial data base does not exist to provide a clear description of the specific population groups served, or to determine if the available arrangements are accessible and are adequately meeting the health care needs of all the groups within their communities. Some arrangements, including the Health Service Organizations and Health Centres, have attempted to provide comprehensive health care to consumers in ways that facilitate ease of access, continuity of care and integration with the necessary social services to support the health care. Although these services have not been critically appraised, we do know that these arrangements provide considerable professional satisfaction for the health care professionals involved and that they are also well-liked by many consumers. Again, we do not know what proportion of the population uses comprehensive and integrated arrangements, other than Health Service Organizations/Health Centres, or what the burden of illness or the overall effectiveness or efficiencies of any of these service arrangements are. There is, however, some evidence in Ontario that certain group practice arrangements, including Health Service Organizations and Health Centres, do reduce the need for institutional care[16].

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*For example, the Ste. Anne Clinic in Ottawa. See: "Health Service Needs Survey", Ste. Anne Clinic, Ottawa, 1981. Also, York Community Services, Toronto, has informally documented the health needs of certain high risk population groups in their neighbourhood.

It is clear that the population is not homogeneous and the demands for health care services vary, not only because of the burden of illness, but because of other factors such as age, sex, ethnic and cultural influences. What is emerging in Ontario is a publicly-funded, pluralistic system for providing primary care to a heterogeneous population. This is desirable, if one is to meet the diverse needs and demands of both consumers and providers of services. The problem is to fund this pluralistic approach to providing primary care services in a manner that is both equitable and has a form of accountability that does not interfere with professional responsibilities for providing health care.

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[16] Health Care Report: Sault Ste. Marie District and Group Health Association and the Glazier Medical Centre, Oshawa. Toronto: Ontario Ministry of Health, Data Development and Evaluation Branch, 1976.

There are a number of reports indicating that the arrangements for providing primary health care services are important determinants of the efficiency and the effectiveness of an entire health care system (for example, Enthoven[17]). A wide variety of arrangements can be used for the provision of primary health care services and take into account the different needs of the population while providing for a variety of professional roles and arrangements for the provision of these services. It is apparent that, if attempts are made to solve the needs for primary care services by providing one solution, some sectors of the population will not be adequately serviced and the system may be less efficient than could be achieved by a pluralistic approach with incentives for efficiency. A number of Health Centres have suggested that an ideal health care system should take into account:

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[17] Op. Cit.

a) the nature and role of health care services;

b) the need for a strong provider-consumer focus, sensitive to the varied needs and demands of consumers;

c) the need for accessibility to services with minimal or no financial barriers;

d) the need for incentives to ensure the efficient provision of high quality health care;

e) the need for decentralized arrangements that allow for pluralism and diversity to reflect the varied needs of different population groups;

f) the need for systems that can adjust to meet the changing needs for health care and the continuing advances in understanding of health problems.

1.2 SCOPE OF PRIMARY HEALTH CARE SERVICES IN ONTARIO AND SOME OF THE ISSUES

One of the earliest developments in primary care in Ontario was physicians organizing themselves into group practice arrangements. In some parts of the province, this is the major organizational arrangement for the delivery of primary care. There is evidence that many of these groups provide very high quality care efficiently.[18] These arrangements appear to be very attractive to both providers of care and to consumers. In addition to physician-organized group practice arrangements, Ontario has also seen the development of group practice arrangements under the auspices and stimulus of local community groups. One of the earliest developments of this kind in Ontario was in Sault Ste. Marie in 1963 when the United Steelworkers initiated the establishment of a community health centre.

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[18] See, for example, Bachelor, G.M., et al. The Burlington Randomized Controlled, Trial of the Nurse Practitioner. Hamilton: McMaster University Faculty of Health Sciences, 1975.

By the early 1970's, Ontario was supporting a number of community health centre models in Ottawa and Toronto. In 1973, the Ministry of Health formulated a policy which stated that it "would support the evolutionary development of organized community health services"[19] provided that there would be no additional cost to the government and that the development of such health services would not be initiated by the Ministry. Initially called "Community Health Service Organizations", this was later modified to "Health Service Organizations". While an Health Service Organization could be sponsored by any group, "each was to have some of the following characteristics:

1. Continuity of care would be emphasized rather than high volumes of episodic care.

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[19] Overview of the Health Service Organization Project. Toronto: Ontario Ministry of Health, Program Development Branch, 1982.

2. Care would have a basic health rather than a disease orientation.
3. Economy and effectiveness would be achieved by use of the services of other health care professionals, such as nurse-practitioners and community workers, in place of physician services where appropriate.
4. The resources of the public health system, already publicly financed, would be utilized.
5. The resources of the social service system would be utilized by establishing co-operative management."[20]

The Ontario initiative occurred at a time of significant social concern. Particular concern over the effectiveness of health care delivery had resulted in national, provincial and community initiatives. At a Federal level there was the 1973 Hasting's Report, The Community Health Centre in Canada[21] which called for the establishment of community health centres. This report described the criteria for qualifying as a community health centre as:

a) offering a comprehensive range of health and social services;

b) employing multi-disciplinary teams of physicians, other health care workers and social service workers;

c) having a strong emphasis on primary prevention and health promotion;

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[20] Ibid

[21] Hastings, J.E.F., The Community Health Centre in Canada. Ottawa: Information Canada, 1973.

d) having an alternative funding arrangement to fee-for-service payment, which was not deemed appropriate for multi-service community health and social centres;

e) being under the control of a community board of directors which would be responsible for detailed planning, priority setting and preparing and administering budgets.

In 1974, the Health Planning Task Force of Ontario recommended a number of proposals for a comprehensive plan to meet the health needs of the people in Ontario. This Task Force made some specific recommendations with respect to primary care. In particular, the primary care sector should be developed to fulfill the following responsibilities:

1. Provision of primary contact for the public with the health system, 24 hours a day and seven days a week.
2. Complete and continuous responsibility for the health care of the individual and the family, including promotion of preventive measures and the need for health maintenance on the part of the individual.
3. Determination of the kind of health services that are required by the individual at a given time.
4. Provision of health care based on a continuing health professional/patient relationship that is characterized by mutual confidence and understanding.
5. Establishment of arrangements for the sharing of tasks and the delegation of responsibility among all health personnel in the group in order to achieve optimal efficiency and the provision of health services of high quality.
6. Establishment and operation of an evaluation procedure based on an audit of health services and

a review of the performance of health personnel by their peers.

7. Provision of recommendations to the proposed District Health Councils Advisory Committee regarding requirements for primary care health services and distribution of these services.
8. Provision of recommendations to the proposed District Health Councils Advisory Committee concerning manpower requirements for the primary care sector.

Changes in expectations of the public, technology and institutional roles placed increasing demands on the health sector, raised new questions as to directions to pursue, and produced tensions between the professionals and the government. In response to this, the Ontario Medical Association, recognizing a division of opinion among itself, the public and the government initiated a "Special Study Regarding the Medical Profession in Ontario" directed by Edward A. Pickering.[22] This study, completed in April of 1973, revealed significant public concern about primary health care services; in particular, about the supply and availability of general practitioners. The survey also identified a public interest in one-stop group practices, the use of para-medical personnel and a need for "neighbourhood doctors who live and work with the poor in depressed areas."

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[22] Pickering, E.A., Report of the Special Study Regarding the Medical Profession in Ontario, Toronto: Ontario Medical Association, 1973.

In 1975, a detailed description of primary health care services in the London area was prepared for the local District Health Council.[23] This report clearly documented the diversity of the arrangements for providing primary health care services. It also indicated some of the problems arising from difficulties in achieving co-ordination among the different components. Since there has been no broad policy for the development of primary care services in Ontario, it is, therefore, not surprising that when one takes a central planning overview, the system appears to be fragmented. Further, it is also not surprising to find fragmentation in a health care system that has evolved largely through ad hoc arrangements in different parts of the province.

How the primary care resources are used depends on many factors: the patient's knowledge of the services available, the professional's awareness of the services available, the demands of the patient, availability of resources, and the patients' access to them. The classic paradigm of primary care is that of a patient consulting his family physician who initiates and coordinates the care. In reality, the patient may first consult relatives or friends. The first contact with a professional may be with a pharmacist, chiropractor, social worker or theologian. In northern communities, the main provider of primary care services is often a nurse.

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[23] McWhinney, I.R. Primary Health Care in London, Ontario. Report to the London Health Council, 1975.

In many communities individuals who are ill seek their initial care from the hospital emergency room. This can arise because the time of day is such that their own physician is unavailable or because they are individuals who do not have roots in the community and identify the hospital as the place to go to in order to receive care. Some physicians qualified for specialist practice and serving as consultants also provide primary care. In a number of countries, such as the United Kingdom, it has been found, particularly in large metropolitan areas, that there can be a shortage of primary health care personnel including physicians, especially in lower socio-economic class areas.[24] We do not have data to indicate whether or not this is a major problem in large metropolitan centres in Ontario, but some aspects of this problem were described in the

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[24] Jarman, Brian, A Survey of Primary Care in London: A Report prepared for the Royal College of General Practitioners. Occasional Paper No. 16, London, May, 1981.

Pickering Report. He wrote:

> "Societal problems loom large. There is disturbing evidence of unequal standards of care, depending upon economic status, age, place of residence and ethnic origin which should be the goal of an enlightened democratic and Christian society to eliminate."[25]

That there are areas in which additional support is necessary to provide health care services is evident from the fact that the Ministry of Health and the Ministry of Community and Social Services have both provided special programs for selected services for certain members of the community. Some examples are mental retardation, child abuse, mental health and infant stimulation. It is clear that the development of this spectrum of services to meet these needs does help add to the diversity of primary care services. It also increases the pressure to: achieve more co-ordination among the services; enable a better identification of the population groups who need these services; increase the effectiveness of these services in meeting the needs of special population groups. Unfortunately, there is a limited data base with which to assess the magnitude of the problems or any special needs that should be addressed. However, it is important to point out that part of the community health centre concept is based on a professional perception of needs and of requirements for special arrangements to meet the health care and social needs of the population groups they serve.

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[25] Op. cit.

Government of Ontario Policies

The Government of Ontario's policies regarding Health Service Organizations and Health Centres were an appropriate response to the concerns and issues identified at that time. Nine years later, in 1982, there are 17 Health Service Organizations and 10 Health Centres with an estimated total client population of 150,000-200,000. They fall into the following general categories:

- Sponsorship
    - Physicians
    - Community
    - Institution
- Funding
    - Capitation
    - Global Budget
- Program
    - Medical
    - Medical with associated community and social services
    - Multi-service Centre

While Health Service Organizations and Health Centres provide care to about two percent of the population of Ontario, they have had a major impact in a number of communities. Health Service Organizations are the only source of health care for the communities in the area of New Hamburg, Sharbot Lake and Freelton. In the communities of Sault Ste. Marie and Parry Sound, approximately 50 percent of the population is served by an Health Service Organization. In the Metropolitan area of Hamilton-Burlington almost 10 percent of the population is registered with an Health Service Organization, including the entire practice population of the Department of Family Medicine of McMaster University. Six Health Centres in Toronto and three in Ottawa serve socio-economically deprived populations.

Innovative programs in health promotion, health education and health services have been instituted by some Health Service Organizations and Health Centres. Notable examples are the nurse-practitioner program at the Caroline Medical Group in Burlington and the health promotion project at Centretown Community Health Centre in Ottawa. York Community Services in Toronto has developed a shared medical program with the Public Health Department of that municipality.

The development of these new arrangements for primary health care services such as the Health Service Organization and Health Centre programs has not been without its difficulties. There have been problems among professional groups in terms of the acceptability of these new arrangements; among consumer groups, communities and providers in terms of suitable arrangements; in professional values and goals and inter-professional relationships; and in setting up suitable financial arrangements which achieve both equity of resource allocation and some form of accountability, (for example, a record of the services provided and payment for service provision). It is not surprising in a complex area such as this, without a clearly-stated, broad overall policy and without sufficient experience to know what suitable guidelines for development should be, that there would have been problems such that some of these attempts under the new arrangements have failed.

Despite these problems and difficulties, the developments that began in the 1970's have demonstrated that within primary health care services, the development of a pluralistic approach is possible. Our experiences with these new arrangements have shown that those groups which are effective: can decrease unnecessary utilization of institutional services such as active treatment beds; can work productively with a variety of professional services to achieve co-ordination and integration; and can allow for the evolution of expanded roles for health professionals in the system. These new developments in primary care services include: solo family physicians working in a co-ordinated manner with other services in the community such as public health nursing and social work; group practice arrangements operating under strong professional leadership to provide sensitive, effective, efficient health care; Health Service Organizations with their incentives to provide health care efficiently; Health Centre programs designed to provide integrated health and social services to populations with complex needs.

In addition to its leadership in new practice arrangements, Ontario has also been in the forefront of other developments in primary care. They include training programs for physicians in family medicine and for nurses in primary care. Leadership in research in primary care, both nationally and internationally has come from Ontario, the most recent example being the publication of an index to the international literature on primary care (FAMLI)*.

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*Family Medicine Literature Index.

Community health centres have, in the past, been associated with the issue of a 'two-class" health care system: one class for the poor, elderly or disadvantaged in society, and one for the remainder. The efficient primary care organization and particularly the community health centre concept can and should be applied to the provision of health care to all segments of society.

The concept of multiple arrangements for providing care should not necessarily be cast in a negative light for it does not have to imply different standards of care. Instead, it can mean the availability of additional services to those with an additional burden of ill health. In a pluralistic society with pluralistic needs it is reasonable to expect that some groups with special needs will need additional services and suitable arrangements for providing these services. The community health centre is one model of primary care delivery which is especially suited to fulfilling this role because of its flexible organization, population-based planning approach and co-ordination and integration capacities among the human service disciplines.

In this report we will attempt to examine some of the problems that have surrounded these primary care developments. The problems involve both financial and administrative aspects as well as professional and consumer issues. In addition, we will attempt to examine how these developments can be used to facilitate future development. The developments provide a base for a pluralistic approach to primary health care that can be effective and have built-in incentives for the efficient delivery of health care. As well, these developments have demonstrated a capacity to meet the diverse needs of a heterogeneous population that places varying demands on health care services.

The role of government in these new developments is complex, but the government has some responsibility since it fully or partially funds most of the services. The government therefore has the responsibility to ensure its policies, including funding arrangements, are compatible with supporting the new developments in the primary health care sector, in addition to those that are well established.

RECOMMENDATIONS

1. IT IS IMPORTANT THAT THE POLICIES OF THE GOVERNMENT OF ONTARIO WITH REGARD TO ITS SUPPORT FOR HEALTH SERVICES BE SUCH THAT THEY ALLOW FOR THE DEVELOPMENT OF A VARIETY OF ARRANGEMENTS FOR THE PROVISION OF PRIMARY HEALTH CARE IN ONTARIO.

2. SINCE THE DEVELOPMENT OF HEALTH SERVICE ORGANIZATIONS AND HEALTH CENTRES HAS BEEN IN PART A RESPONSE OF PROVIDERS AND CONSUMERS TO SPECIAL NEEDS IN THE PROVISION OF HEALTH SERVICES, WE RECOMMEND THAT THESE DEVELOPMENTS BE ACCEPTED AS TWO LEGITIMATE FUNDING MODELS FOR THE PROVISION OF PRIMARY HEALTH SERVICES IN THE COMMUNITY.

SUMMARY

1. The important determinants of human health are largely related to how one lives, where one lives and depends heavily on one's socio-economic background.

2. There is evidence from many countries, including Canada, of inequalities in health related to socio-economic class that have implications both for the determinants of human health and the needs of the health care system.

3. The effectiveness of the arrangements for the provision of primary health care services is an important determinant of the efficiency of the health care system.

4. The health care services provided in the community have a significant impact on the quality of human life.

5. Health Care Services: Because the disease burden is differentially distributed among the population, the burden being higher among some income, ethnic and social classes than others, and because people differ in the ways they use health services, depending on cultural and other factors, we have a heterogeneous population that requires a mix of health services.

This can range from individuals who select for themselves the professionals they want to provide the kind of services they want at a time of their own choosing, to individuals who would like to have a more continuing support, embracing a range of services. In the past 20 years in the Province of Ontario, practice arrangements for primary health care services have developed that include organizational arrangements for an even broader array of services in primary care, for example, Health Centres. Thus, already, Ontario has shown it has a capacity to respond to the heterogeneous needs of the population for health services. It seems certain that this heterogeneity will have to be respected in any further developments of health services in the Province.

6. With the increased proportion of the population in the older age group, there will be increased demands on health care services, particularly primary care services, over the next ten years.

CHAPTER 2

HEALTH CARE POLICIES IN PRIMARY CARE

INTRODUCTION

As discussed in Chapter 1, the health care services provided in the community, often referred to as primary health care, play an important part in influencing the quality of human life. They can:

- decrease morbidity
- prevent the flare-up of acute episodes in individuals with chronic illness
- play an important part in rehabilitation
- provide effective therapy for treatable conditions
- help support and maintain individual independence in the community
- contribute to individual understandings of health issues
- help to promote positive approaches to dealing with the impacts of life style and environment on human health.
- provide primary and secondary prevention.

Further, their support for individuals in the reproductive periods of their lives and for young infants can have a significant impact on human life expectancy.

The needs of the general population for curative, rehabilitative, preventive, educative, supportive and environmental services are common to all communities. However, the weighting given such needs will be different in each community depending upon socio-economic, ethnic and geographic characteristics. Some groups have greater health risks than others: the elderly more than the young; some immigrant groups more than others; low income families more than middle income families. Northern Ontario and rural parts of the Province frequently also have different problems from the South and large metropolitan areas. Accordingly, health care policies should allow for the development of primary care services that take into account the varied needs of population groups, are accessible to everyone regardless of ability to pay, provide effective health care services efficiently, can be coordinated with other related human services and are appropriately accountable to the community.

PRIMARY HEALTH AND SOCIAL SERVICES

Urban centres today have a multiplicity of human services sponsored by either public or voluntary agencies. These health, social, recreational, cultural and educational services are available to meet needs from infancy through adult years. Such services are not, however, equally distributed throughout the province. Rural areas and smaller centres may lack some services; on the other hand, it is difficult to develop an exhaustive list of what is available in metropolitan areas. Nor are services always distributed within metropolitan centres according to the needs of different population groups. As a consequence, consumers can have difficulty locating services, and there can be problems securing coordination among some of the services.

The initiative for many of our present services originated in neighbourhood churches, ethnic and cultural associations and settlement houses in response to local needs. During the 1930's, the growth in government programs and increasing professionalization in all fields led to agency consolidation and centralization. While many services continued to be administered at the neighbourhood level, most planning and policy decisions were made by centralized bureaucracies. By the early 1960's, however, concern with the problems of youth and "multi-problem" families resulted in a return to new local initiatives.

This return to the neighbourhood level was distinguished from the past by the replacement of volunteers and partially trained personnel with professionally trained individuals and teams, accountable to centralized agencies. Inevitably, as community groups became better organized and more sophisticated, demands arose for some redistribution of decision-making. Groups of consumers began to search for new structures which would enable local communities to plan for needed services rather than having either government or private agencies plan for them.

During the late 1960's and early 1970's, a number of public reports such as the Castonguay[1] and Hastings[2] stimulated governments to become receptive to the development of community health centres, multi-service centres, community law clinics, information centres and a wide variety of other neighbourhood centres designed to meet specific local needs. These initiatives usually involved local community participation in planning, the development of competent local leadership and the matching of demands to appropriate services.

Just as evolution occurred in the organization of non-medical services in primary care, the medical services component of primary care also began to change. The traditional source of care for most families has been, and continues to be, the solo general practitioner. During the past 20 years, however, two developments have improved the ability of these practitioners to respond to the demands of patients and their families. First, the evolution of the specialty of Family Practice has called attention to the need to prepare physicians for primary health care in a manner that takes into account the kinds of patient problems they will have to care for and their pivotal role in determining the effectiveness and efficiency of health care services. Second, increasing numbers of practitioners have realized the significant benefits to both their patients and themselves of some arrangement for group practice. These arrangements have helped to enhance accessibility to health care services and in many instances have been found to be among the most efficient for providing high quality care. Thus, there has been a growing tendency to provide primary care services through groups of physicians in cooperation with other health professionals.

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[1] Castonguay, C. (Chairman), Commission of Inquiry on Health and Social Welfare. Province of Quebec, 1967.

[2] Hastings, J.E.F., (Chairman), The Community Health Centre in Canada, Ottawa, Information Canada, 1973.

ISSUES AND CONCERNS

These developments, when seen in the context of the changing demands and expectations of both consumers and health professionals, have led to some complex issues and problems that need to be addressed, if further developments are to be facilitated. Among the issues and problems are the following:

a) suitable funding arrangements for the various primary care services with appropriate accountability

b) mechanisms for planning primary care services and establishing priorities

c) arrangements for estimating the health status of the population and the demands for service

d) equity in the provision of services to the population according to risk

e) the needs/demands of the consumer

f) incentives to improve the efficiency of primary care and overall health care services.

These broad issues contain many sub-issues such as the efficiency of emergency care services; the relationship between primary and secondary care services, and the problems of practicing "defensive" medicine.

In considering these problems, it is useful to have an appreciation of the kinds of services that are now part of the medical and social services available for primary care. Table 1 outlines the kinds of services that are currently available. An individual can access these services through a variety of arrangements. He or she may seek out individuals for specific help in one of the service areas listed. Some may seek help from a centre which tries to offer all of the services in one location. Other individuals may access their medical care through a family physician; their dental care through a dentist, and their legal help through a lawyer.

The problems are further complicated by the fact that the funding arrangements for these services are diverse. For example, most medical services are funded by the government through its health insurance program; however, only a small proportion of legal services are funded publicly. Coordination among these services is difficult and the problem may be compounded when multiple funding mechanisms are involved. In this regard, the community health centre is a notable model in that it attempts to meet the needs of the population that is most dependent upon services provided by government or voluntary agencies by coordinating and integrating these services.

In addressing the issues and concerns we have identified the Task Force is not recommending a single solution, but rather advocates the development of specific policies that allow for a pluralistic approach to providing primary health care services to a heterogenous population within a broad public policy of social equity. It is clear that a solo practitioner solution will not meet the needs of certain population groups and conversely, community health centres will not meet the needs of others.

In the view of the Task Force, it is important to recognize that the kinds of health and human services an individual wishes to access will be heavily influenced by the background, values and attitudes of the individual, rather than by income status alone. Since not all services are publicly-funded, it is important that the funding mechanisms for these complex services not be such that they preclude the development of coordinated arrangements involving a mix of private and public funding to provide a full range of services to interested consumers.

TABLE 1

The Population/Service Matrix*

TYPE OF PRIMARY HEALTH CARE SERVICE OR PROGRAM		TYPE OF POPULATION	
	Typical	Atypical	High Risk[1]
		special needs, but not high risk	. poor . aged . chronically ill . mentally ill
Clinical (medical) Services			
Health Promotion/ Illness Prevention			
Counselling			
Legal Assistance			
Housing Assistance			
Social Services			
Other: e.g. . Dietary . Employment			

*Note: This grid represents a model that can be filled out as appropriate to the needs of the population being served. For example, how great is the health need in each cell? To what extent do current arrangements for primary care services meet these needs? What funding mechanisms are there for the services in each cell? What funding mechanisms are most appropriate for each cell?

[1] "High Risk" is defined here according to the categories in the Task Force's terms of reference. Other definitions may, of course, be substituted.

PLANNING AND PRIORITIES

There is a need for organizational structures which can facilitate the planning of health services at a Federal-Provincial, Regional, Municipal or Community level. These arangements must allow for central consolidation of data when appropriate and free inter-change of the data between different levels of planning. They should obtain support for the coordination of all sectors at the local level. They should obtain the assistance of government in developing a local capacity to meet health and social aspirations and to respond sensitively to practical problems and needs.

Within the Provincial Government, there is a need for a "lead Ministry" in relation to health services' planning and priorities. Because several Ministries are involved in developing the policies and funding arrangements for some of these health-related human services, it is obviously not appropriate for the Ministry of Health to assume responsibility for the detailed planning and priorities for these services in other Ministries. However, it seems logical for the Ministry of Health to be the "lead Ministry" for bringing together other groups within government to create effective planning and priority-setting for the long-range development of these health-related human services.

At the local level, there are various groups involved in planning such as District Health Councils, Social Planning and Research Councils and Regional Planning Councils. Of these, the Ministry has charged the District Health Councils with health planning at the local level. Since District Health Councils have begun to play a major part in assisting local groups in planning and priority setting for health services, it would seem logical that District Health Councils should also play a major part in facilitating planning by local groups for the provision of primary health care services. It is important that these local planning arrangements be linked with the centralized role of the Ministry.

In addition, the Task Force recognizes the complex problems associated with planning and priority setting in this area. There are two aspects that should be addressed. First, the Ministry of Health should establish, in collaboration with other relevant Ministries, an arrangement for developing an effective data base describing the health status of the population and its utilization of health services in relation to its disease burden.

Secondly, the problems associated with local planning are also complex. The Task Force believes the Ministry should work with its District Health Councils and through them, with other related agencies in the community to establish local planning arrangements for the development of community health services. In developing these arrangements, the Ministry should try to facilitate the establishment of criteria for setting priorities for developments at the community level, in consultation with local community groups. Where District Health Councils are not well enough established, the Ministry should work with other agencies at the local level (such as Public Health Units) to try to develop local planning arrangements.

The role of the public health units in the provision of primary health care services needs careful consideration with respect to the new developments. Public health nurses have played a key role in providing health services to sectors of the community not receiving adequate services from other professional sources. In addition, many public health nurses work with primary care physicians so as to provide integrated medical and nursing services in the community. It is important that the public health units be involved in community-based planning and that their resources and application to primary care services be taken into account.

As recommended in previous reports, such as the Report of the Health Planning Task Force[3] and various reports of the Ontario Council of Health, the resources of the Health Sciences' Faculties in Ontario should continue to be used to assist in local planning. Where necessary, these resources should be strengthened to assist the District Health Councils and other agencies to execute their planning and priority setting.

CONSUMER NEEDS AND EQUITY

Ideally, consumers are involved in community health services on at least two levels. First, they make use of the services; secondly, they may take part in influencing the kinds of services that are available. The latter influence can occur through various routes. For example, by seeking help from only certain kinds of individuals or groups in the system they can create a "market-place" effect on the supply and demand for services. Or they may actively come together and create their own boards to operate the services which they and the local professionals feel are needed by the community. It is clear, therefore, that there is no single solution for community involvement at the local level. Once again, flexible policies are required to meet the pluralistic needs of a heterogeneous population.

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[3] Mustard, F. J. (Chairman): Report of the Health Planning Task Force. Ontario, 1974.

An important consideration in community involvement is the availability of information about health services and health problems. Arrangements should be developed that encourage health providers and health planners to facilitate consumer understanding of available health services and health problems.

A more difficult issue is to ensure that there is broad equity in resource allocation to meet the needs of consumers. For example, in a humane society, individuals who have greater disease burdens than others will be allowed to place greater demands on health services, regardless of their relative tax contributions, e.g. children, the aged and people with congenital disorders. Organizations providing services to such population groups may therefore have much higher costs because of the mix of the population being served. How to maintain broad equity in funding to meet the variability in disease burden among populations is a very difficult issue that should be taken into account by the planning function.

EQUITY IN THE PROVISION OF HEALTH SERVICES ACCORDING TO RISK

In the opinion of the Task Force, an important principle in making services available and accessible is ensuring that service planning takes into account the variation in risk of different population groups. Geographically remote areas may have poor resources, including shortages of manpower. Certain areas, with potentially good resources, including parts of Toronto, may be functionally inaccessible to those who cannot or do not enter the system because of:

i) a language barrier
ii) a lack of education
iii) the traditions of certain cultures
iv) poor transportation facilities
v) a shortage of health professionals of preferred sex.

In addition, there are problems of physical inaccessibility for some people, such as the aged or the physically handicapped.

FUNDING ARRANGEMENTS

As indicated in the introduction to this report, a major issue is how much of the province's wealth should be spent on health care services. There are also increasing pressures to ensure that services are provided as efficiently as possible. There is substantial evidence that the efficiency of health care services is heavily influenced by the organizational arrangements and incentives for providing primary health care. In order to facilitate understanding of this complex area, we had prepared a special report on Health Centre Funding which is attached as Appendix A to this Report. This addendum serves as the basis for some of the recommendations in this report.

The overriding funding issue appears to be the development of arrangements that can ensure that providers can offer sensitive, high quality care efficiently to consumers of health services in a manner that is equitable and acceptable to all sectors of the population. Over the years, a number of recommendations have been developed for achieving this (e.g. The Committee of the Healing Arts (1970)[4]; Castonguay (1970)[5]; Hastings (1973)[6]; Mustard (1974)[7]).

There are basically four arrangements whereby the government can fund the provision of services in the primary health care field: 1) fee-for-service; 2) capitation; 3) budget (line-by-line, global or program-based) and 4) direct salary. Each of these arrangements has an impact on how health care services can be organized and provided. From a government point of view, a major consideration is whether the funding arrangements are providing a given standard of service for the least resource cost. This may be termed "the technical efficiency component". Another consideration is whether the funding arrangements are providing the right mix of services and the right amounts of each service which might be termed "the allocative efficiency component".

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[4] Report of the Committee on the Healing Arts, Toronto: Queen's Printers, 1970.

[5] Op. Cit.

[6] Op. Cit.

[7] Op. Cit.

In examining this question of funding it is beyond the scope of the Task Force to develop a comprehensive set of funding guidelines. However, two principles appear to be important: 1) both the level of funding and the choice of provider reimbursement mechanism should be appropriate for the population served and take into account provider preferences; 2) the overall system of primary care funding should contain incentives for the efficient provision of effective services.

Table 1 outlined some of the kinds of human services that are now available to an individual. Because of the mix of people to be served and the mix of services being offered, the funds will be derived from several sources. The mix of services being provided by an organization will determine the funding arrangements.

The Health Service Organization and Health Centre models may be thought of as covering a spectrum from a "physician-sponsored capitation practice" at one end to a full-fledged Health Centre meeting all the criteria of the Hastings Report (as detailed in Chapter 1), at the other. Under the Health Service Organization umbrella, various experiments in Ontario have resulted in three basic models:

The Physician-Sponsored Model - Owned and operated by physicians in a group practice.

Community Board Model - A non-profit corporation or association controlled by a board of trustees, nominated and elected by the roster members and the community.

Family Practice Unit - Sponsored by a health science centre or hospital and located in the community or within a hospital.

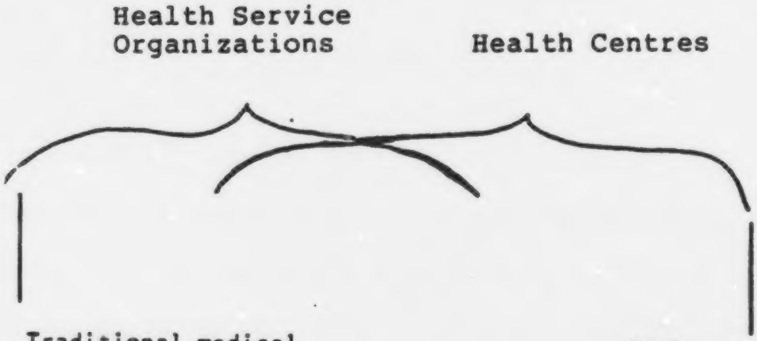
Variations on the health centre model exist in every province except P.E.I. and New Brunswick. Quebec has produced the greatest number, following the Castonguay Report, called Centres Locales des Services Communantaires (CLSCs).

As this report focusses primarily on the Health Service Organization and Health Centre arrangements, it is useful to consider the spectrum of services they provide and their funding arrangements. At present, policy development is difficult partly because there is no programmatic separation of capitation-funded organizations, (labelled "Health Service Organizations" by the Ministry) from globally funded organizations (labelled "Health Centres" by the Ministry).

The nature of the key funding and accountability issues in globally-budgeted centres is different from those in capitation-funded centres. Many people view such organizations as similar even though they are supported financially by different mechanisms. These organizations comprising the Health Service Organization/Health Centre network can be viewed as falling along a spectrum, as illustrated in Figure 2. This spectrum reflects in part the origin of the centres currently in the network. At one end are those that have developed with a more traditional medical focus and initiative, while at the other end are those which arose out of community-based groups trying to establish a broad health service organization.

FIGURE 2

The Community Health Centre Spectrum



Traditional medical orientation
- alternative payment mechanism to fee-for-service

CHC's as envisioned in the Hastings Report
- comprehensive health and social services
- multidisciplinary teams
- emphasis on illness prevention/ health promotion
- community board
- alternative payment mechanism to fee-for-service

Any development of the funding rationale to support these organizations has to take into account not only the way they were developed but also the complex nature of the services they are trying to provide. Thus, for an organization which has developed with more of a medical focus, capitation or a fee-for-service may be the best arrangement. But for other organizations that include a broader range of services, a capitation arrangement may be impractical.

FUNDING ISSUES IN PRIMARY HEALTH CARE

There are many issues in this area ranging from debates about the strengths and weaknesses of fee-for-service payments and what types of care should or should not be covered by the system; the benefits and limitations of capitation; the benefits and limitations of incentive programs, and the benefits and limitations of salary arrangements. In this report, it is not our intention to spend time discussing fee-for-service arrangements in any detail since the Task Force's Terms of Reference focussed specifically on the groups administratively referred to as Health Service Organizations and Health Centres. However, it is important to point out that fee-for-service provides an incentive to deliver services; fee-for-service is consistent theoretically with the government's goal of technical efficiency and can be used to influence the mix and amount of services provided (allocative efficiency). These and other issues should be the subject of a more detailed analysis of the whole primary care area. Our specific concern is with the funding arrangements for Health Service Organizations and Health Centres. In particular, for Health Service Organizations, the funding issues centre around capitation arrangements and the Ambulatory Care Incentive Program (ACIP) arrangements. In the view of the Task Force, there is no debate about the value of capitation payments in principle as an alternative payment arrangement, nor about the administrative arrangement known as "capitation negation" which Ontario has evolved. The issues for Health Service Organizations revolve more specifically around the details of how to determine an appropriate capitation rate and the appropriate use of the ACIP plan.

For Health Centres, the issues centre around uncertainty of funding, the appropriateness of global funding mechanisms, and what the level of funding should be. The evaluation and accountability issues when establishing new funding arrangements will always be problematical. An important question is "what is the appropriate comparison?" For example, if Health Centres are compared to fee-for-service arrangements, the problem is that the comparison does not take into account the full impact of the funding arrangements. A Health Centre that is providing care that covers a range of medical and health-related human services, as outlined in Table 1, has a different cost structure per unit of service than the cost of a physician providing only the medical component of the services. If the provision of an integrated service helps keep the individual self-sufficient in the community, whereas the provision of more limited medical services fails to do so, the social costs will be different. Unfortunately, while the concepts can be set out, there are no satisfactory studies showing whether one type of service can provide a better outcome in terms of social cost than another arrangement. Until such time as a strategy can be evolved for comparing different funding arrangements and for estimating the full social costs and benefits of the different funding arangements for health care services, it will be difficult to have any benchmark which allows for an equitable comparison.

With global funding arrangements, which may include direct salaries for practitioners, there is difficulty in maintaining incentives for both technical and allocative efficiency. A further problem is knowing what is being paid for and ensuring some form of accountability. Least desirable is a line-by-line budget management relationship which could result eventually in the government determining what the professionals do in the provision of health care services. While recognizing that the Provincial Government does provide some direct health care services, this Task Force does not endorse the government becoming further involved in the direct provision of care in the health sectors discussed in this report. It is important that the services provided for the care of individual patients be determined through a provider/consumer interaction. The overall scope and quality of services, however, will be determined by many factors, including the efficiency with which professionals provide services, government policy with respect to resource availability, and which services it is prepared to fund.

CAPITATION

It is clear in considering capitation as a method of funding that a basic concern is the formula that is used to calculate the capitation amount. The main criticisms of this formula are:

1. It does not take into account the "burden of illness" of the population served, i.e. to the extent that the population served differs on dimensions other than age and sex from the general Ontario population on which the capitation rate is based, the rate can under (or over) fund the centre. For example, if an organization's patient-population is "sicker" than average, it deserves a higher than average rate.

2. In calculating the capitation rate, (i.e. the age-sex adjusted average cost per capita of provincially insured medical services) it is inconsistent to include the Health Service Organization/Health Centre

population in the denominator but to exclude the Health Service Organization/Health Centre costs from the numerator.

3. In calculating the capitation rate, the entire amount expended by OHIP on medical services, based on claims, is divided by the census population to achieve a per capita rate for each specialty. However, the per capita rate is only paid to the Health Service Organization for eligible (those with paid-up premiums) roster members.

The Ambulatory Care Incentive Program (ACIP) has shown itself as a possible mechanism to increase the efficiency of the health care system. However, like all new programs, there are some problems which should be addressed.

Among the criticisms made by the Health Service Organizations are:

1. The calculation of the proportion of "saved" hospitalization cost that is to be returned to the practice should employ current figures on per diem hospital costs.

2. The determination of the proportion of "savings" to be returned is arbitrary and should be based on some more rational formula.

3. The comparision population needs to be refined in order to age-sex adjust the computation.

The administrative arrangements have also caused some concern regarding:

1) the availability of capitation-negation information to the Health Service Organizations. Without violating confidentiality, greater and more accurate information needs to be fed back to practices which would assist them in their management.

2) capitation payments are not updated quickly enough.

The Task Force believes it is important that the Ministry of Health work with the Health Service Organizations to resolve these and other issues.

This list of issues is not necessarily exhaustive but provides examples of the kinds of problems that arise with the evolution of any innovative funding program in the complex field of health and human services. It takes time for the refinement of specifics.

As discussed earlier in the Report the effectiveness and efficiency of health care services is to a large extent determined by the primary health care sector. The present Ambulatory Care Incentive Program only relates to a small segment of primary care services. As we have indicated, there are medical group practices and other fee-for-service arrangements that appear to be as effective as the Health Service Organization and Health Centre arrangements for providing primary care services. It is important that the incentive payment programs be extended to all primary care sectors. This is crucial for the overall performance of the system and is also necessary to ensure that there is reasonable equity among the providers of primary health care services.

In the long run, it will probably be necessary to integrate primary and secondary care services so that all benefit from gains in efficiency. Present funding arrangements do not give the hospital sector much incentive to support the development of an efficient primary health care sector. This is an important and complex area that requires further study.

FUNDING OF HEALTH CENTRES CURRENTLY ON BUDGETS

There are currently three types of budget funding arrangements: line-by-line, global and program-based. As noted above, the line-by-line budget has the disadvantage of involving government in operating services much more than is desirable. Similarly, the global budget arrangement has the disadvantage of being based on formulae which are not related to programs or people. Merely "tinkering" with formulae does not resolve the major problems. The program-based budget seems to be the best solution.

The funding of community health centres should be based on the programs that they provide and the population they serve. It is recognized that because of the mix of services, the funds will come from a number of agencies. If the Ministry of Health takes on the role of being the "lead" Ministry in health, it can help set up arrangements to allow for coordination of funding from multiple government sources and try to facilitate the establishment of an inclusive, negotiated program budget. Ultimately, the financial arrangements for the centres should be based on some formula related to the kind of population served, the type of services provided and the effectiveness of these services. This should be given further consideration by an appropriate group.

It is also recognized that ambulatory care in a primary care setting should not necessarily be confined exclusively to one mode of funding or another because there is no rationale for doing so. Therefore, there may be "mixed" modes of funding, (i.e. fee-for-service, capitation and budget). This also opens up the possibility that, given appropriate situations, fee-for-service practitioners wishing to participate in programs funded by other arrangements can be accommodated.

The long-term developments in primary health care services, their relationships to hospitals and other institutions in the system and the use of incentives for efficiency must be considered within the total context of the provision of health services. In most jurisdictions, some form of local arrangements have had to develop involving both primary and secondary health care services in order to obtain a major impact of incentive plans[8,9]. The kind of arrangements that can develop to provide for integration of primary and secondary health care services are multiple and beyond the scope of this Report[10]. However, as the primary care services develop, it will become important to give serious consideration to what the future arrangements should be between the two levels of care. The Task Force believes that if a more detailed study of the whole primary care

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[8] Lomas, J. and Stoddart, G.L., Health System Reform: Appropriate Incentive Plans for Ontario. McMaster University, Department of Clinical Epidemiology and Biostatistics and Department of Economics, 1982.

[9] Enthoven, op. cit.

[10] Mustard (1974), op. cit.

field is undertaken, the linkages between primary and secondary health care services should be one of the major areas for consideration.

THE ESTABLISHMENT OF NEW HEALTH CENTRES AND HEALTH SERVICE ORGANIZATIONS

Where new groups are to be established, there should be some community group concerned with health services that endorses their establishment and is prepared to support the rationale for their existence. In some areas, the District Health Councils might be the most appropriate body for doing this. In other areas where District Health Councils are not well-established, Public Health Units, Regional Government, Hospitals or other community-based organizations may be better suited to review new proposals. It is clear that in the future more explicit criteria should be developed to allow for the establishment of new groups.

At present, the following points should be considered before the establishment of a new community health centre is recommended:

1) there is a well-defined community need for the health services that is not being adequately met by existing services;

2) the population to be served is identifiable;

3) the proposed program of the centre will meet the needs of the population identified in (2) above; and

4) the program is set up in such a way that it can be evaluated and assessed to determine how closely it meets its stated objectives.

Such proposals should be reviewed wherever possible by the appropriate District Health Council and the Council should recommend to the government whether such a centre should be established.

ASSESSMENT AND EVALUATION

It is desirable to be able to assess the effectiveness of these new programs in primary health care services, together with the older services. Among the points that need to be taken into account are:

1) the effectiveness of the interventions used in providing care (they do more good than harm or than no service);

2) the efficiency with which the services are provided;

3) the outcome in terms of support of individuals in the community and reducing the need for unnecessary institutionalization;

4) how well the services meet the health care needs of the population being served.

At present, it is difficult to do the necessary assessments to allow for rigorous evaluations. However, steps should be taken to develop this capability particularly as improved information systems become available.

RECOMMENDATIONS

I. FUNDING

1. RECOMMENDATIONS REGARDING HEALTH SERVICE ORGANIZATION (CAPITATION) FUNDING:

   a) HEALTH SERVICE ORGANIZATIONS ON THE CAPITATION-NEGATION FUNDING MECHANISM SHOULD CONTINUE TO BE SUPPORTED BY THE MINISTRY SIMULTANEOUSLY WITH FEE-FOR-SERVICE PAYMENT AS A FULLY DEVELOPED MODEL FOR PRIMARY CARE WITHIN A PLURALISTIC SYSTEM.

   b) THE MINISTRY, IN COOPERATION WITH THE MEDICAL PROFESSION, INFORM HEALTH CARE CONSUMERS AND PROVIDERS ABOUT THE GOALS AND OBJECTIVES OF HEALTH SERVICE ORGANIZATIONS.

   c) THE MINISTRY OF HEALTH, IN COOPERATION WITH THE MEDICAL PROFESSION, INFORM HEALTH CARE CONSUMERS AND PROVIDERS ABOUT THE GOALS AND OBJECTIVES OF HEALTH CENTRES.

   d) THE MINISTRY FACILITATE THE DEVELOPMENT OF NEW HEALTH SERVICE ORGANIZATIONS.

e) THE CURRENT CAPITATION FORMULA USED BY THE MINISTRY SHOULD BE MODIFIED TO PAY HEALTH SERVICE ORGANIZATIONS ON THE BASIS OF THEIR TOTAL ROSTER INCLUDING BOTH ELIGIBLE AND INELIGIBLE ENROLLEES RATHER THAN ONLY THEIR OHIP ELIGIBLE ROSTER.

2. RECOMMENDATIONS REGARDING HEALTH CENTRES (GLOBAL) FUNDING:

a) HEALTH CENTRES CURRENTLY SUPPORTED BY THE MINISTRY ON A GLOBAL FUNDING FORMULA SHOULD CONTINUE.

b) THE BASIS OF HEALTH CENTRE FUNDING SHOULD BE A NEGOTIATED PROGRAM BUDGET RELATED TO THE REQUIREMENTS OF THE PROGRAM OPERATION AT THE HEALTH CENTRE AND THE NEEDS OF THE POPULATION BEING SERVED.

c) GLOBAL FUNDING FOR HEALTH CENTRES SHOULD BE VIEWED AS A LEGITIMATE FUNDING MECHANISM FOR THESE DISTINCT PRIMARY CARE AGENCIES AND NOT AS AN INTERIM ARRANGEMENT FOR FUTURE CAPITATION FUNDING AS HEALTH SERVICE ORGANIZATIONS.

d) THE MINISTRY, IN COOPERATION WITH THE MEDICAL PROFESSION, INFORM HEALTH CARE CONSUMERS AND PROVIDERS ABOUT THE GOALS AND OBJECTIVES OF HEALTH CENTRES.

e) THE MINISTRY SHOULD RECOGNIZE THE NEED AND PROVIDE ADDITIONAL FUNDING FOR THE SPECIAL ADMINISTRATIVE BURDEN INVOLVED IN OPERATING A COMMUNITY HEALTH CENTRE.

3. RECOMMENDATIONS REGARDING AMBULATORY CARE INCENTIVE PROGRAM:

a) ACIP SHOULD BE RECOGNIZED AS AN EFFECTIVE INCENTIVE TO PRIMARY CARE AGENCIES TO REDUCE HOSPITALIZATION AND SHOULD BE EXTENDED TO ALL PRACTICES THAT ARE WILLING TO MEET THE CRITERIA FOR ROSTERING THEIR PATIENTS.

b) THE CONCEPT OF THE ACIP SYSTEM SHOULD BE CONSIDERED FOR EXTENSION TO OTHER ASPECTS OF INSTITUTIONAL SERVICES.

c) THE MINISTRY SHOULD CONTINUE TO REFINE THE ACIP SYSTEM.

4. ALL PRIMARY CARE DELIVERY ARRANGEMENTS, FROM SOLO PRACTITIONERS TO COMMUNITY HEALTH CENTRES, SHOULD HAVE AVAILABLE TO THEM APPROPRIATE FUNDING

MECHANISMS OR A MIX OF MECHANISMS CAPABLE OF MEETING THE NEEDS OF PROVIDERS AND CONSUMERS, IF APPROPRIATE CRITERIA ARE MET:

a) THE MINISTRY SHOULD ESTABLISH AS THREE SEPARATE FUNDING PROGRAMS:

   i. OHIP FEE-FOR-SERVICE
   ii. CAPITATION-NEGATION
   iii. PROGRAM BUDGET.

b) CRITERIA SHOULD BE SPECIFIED FOR PARTICIPATION IN EACH OF THE THREE PROGRAMS.

c) DELIVERY AGENCIES SHOULD BE ALLOWED TO PARTICIPATE IN ONE OR ANY APPROPRIATE COMBINATION OF PROGRAMS.

d) PROGRAM BUDGETS SHOULD BE AVAILABLE TO FUND AN ENTIRE OPERATION (AS IN A COMMUNITY HEALTH CENTRE) OR A PROGRAM COMPONENT (AS IN A FEE-FOR-SERVICE PRACTICE).

II. RECOMMENDATIONS REGARDING ESTABLISHING NEW HEALTH CENTRES

1. WHERE A COMMUNITY GROUP WISHES TO ESTABLISH A NEW HEALTH CENTRE REQUIRING A GLOBAL BUDGET, IT SHOULD BE WITH THE ENDORSEMENT OF A BROADLY BASED COMMUNITY GROUP. IN SOME AREAS, WHERE THE DISTRICT HEALTH COUNCILS HAVE ESTABLISHED WITH LOCAL GROUPS

EFFECTIVE PLANNING ARRANGEMENTS FOR LOCAL CARE, THEY WOULD BE THE MOST APPROPRIATE GROUP FOR DOING THIS. IN OTHER AREAS, PUBLIC HEALTH UNITS, REGIONAL GOVERNMENT, HOSPITALS, OR OTHER COMMUNITY-BASED ORGANIZATIONS MAY BE THE COMMUNITY ENDORSER.

2. THE ESTABLISHMENT OF A MAJOR NEW PROGRAM SHOULD BE DEPENDENT ON MEETING THE FOLLOWING CRITERIA WITHIN THE CONTEXT OF THE SERVICES ALREADY IN THE COMMUNITY:
   - a) THERE IS CLEAR COMMUNITY SUPPORT FOR THE GROUP
   - b) THERE IS CLEAR INDICATION OF NEED OR DEMAND BY THE POPULATION TO BE SERVED
   - c) THERE IS A CLEAR DESCRIPTION OF THE POPULATION TO BE SERVED
   - d) THERE IS A CLEARLY DEFINED PROGRAM THAT WILL MEET THE NEEDS OF THE TARGET POPULATION
   - e) THERE IS A PROCEDURE ESTABLISHED TO EVALUATE THE OBJECTIVES OF THE PROGRAM.

III. RECOMMENDATIONS REGARDING PLANNING AND PRIORITIES

1. THE MINISTRY OF HEALTH SHOULD GIVE A HIGH PRIORITY TO THE OVERALL PLANNING FOR "PRIMARY HEALTH

SERVICES", AS THE TERM IS DEFINED IN THIS REPORT. FURTHER, THE MINISTRY OF HEALTH SHOULD TAKE A "LEAD" ROLE IN FACILITATING COORDINATION BETWEEN ITSELF AND THE OTHER APPROPRIATE MINISTRIES REGARDING THE PLANNING OF OTHER HEALTH-RELATED SERVICES WHICH IMPINGE UPON PRIMARY HEALTH CARE.

2. THE MINISTRY OF HEALTH, THROUGH DISTRICT HEALTH COUNCILS OR OTHER APPROPRIATE AGENCIES, ESTABLISH WITH LOCAL GROUPS, PLANNING ARRANGEMENTS FOR THE DEVELOPMENT OF PRIMARY CARE SERVICES TO MEET THE NEEDS OF THE VARIOUS POPULATION GROUPS IN THE COMMUNITY.

   DISTRICT HEALTH COUNCILS ARE ONE POTENTIAL VEHICLE FOR DOING THIS.

   IF DISTRICT HEALTH COUNCILS ARE TO TAKE ON THIS ROLE IT IS IMPORTANT THAT THEY HAVE THE APPROPRIATE RESOURCES TO CARRY OUT THE TASK.

   IN LARGE METROPOLITAN AREAS, IT IS IMPORTANT THAT THE PLANNING ARRANGEMENTS UNDER DISTRICT HEALTH COUNCILS BE SUITABLY MODIFIED AND DECENTRALIZED TO MEET THE LOCAL NEEDS OF A COMPLEX METROPOLITAN AREA.

3. THE DEVELOPMENT OF COMMUNITY HEALTH CENTRES SHOULD, IF AT ALL POSSIBLE, COME UNDER THE UMBRELLA OF THE DISTRICT HEALTH COUNCILS, BOTH IN TERMS OF TAKING PART IN THE PLANNING FOR COMMUNITY HEALTH SERVICES AND THE DEVELOPMENT OF NEW COMMUNITY HEALTH CENTRES. DISTRICT HEALTH COUNCILS COULD, IN FACT, BE ONE OF THE MECHANISMS FOR ESTABLISHING NEW COMMUNITY HEALTH CENTRES.

4. THE MINISTRY OF HEALTH SHOULD ESTABLISH, IN COLLABORATION WITH DISTRICT HEALTH COUNCILS, A DATA BASE DESCRIBING THE HEALTH STATUS OF THE POPULATION OF ONTARIO BY DISTRICT. IT SHOULD ALSO ESTABLISH MECHANISMS FOR IDENTIFYING HOW THE POPULATIONS AT RISK VIEW THE VARIOUS HEALTH SERVICES ARRANGEMENTS. THIS IS IMPORTANT FOR LONG-TERM PLANNING AND THE ESTABLISHMENT OF PRIORITIES.

   FURTHER, THE MINISTRY OF HEALTH OR THE GOVERNMENT OF ONTARIO SHOULD ASK THE FEDERAL GOVERNMENT WHEN DOING ITS PERIODIC HEALTH SURVEYS TO DO SO IN A MANNER THAT WILL ENHANCE THE DATA BASE FOR ONTARIO.

5. THE MINISTRY OF HEALTH, THROUGH ITS DISTRICT HEALTH COUNCILS AND PUBLIC HEALTH UNITS, SHOULD DEVELOP

LOCAL ARRANGEMENTS FOR PLANNING BASED ON THE HEALTH STATUS OF THE POPULATION AND ITS USE OF HEALTH SERVICES.

6. THE FACULTIES IN THE HEALTH SCIENCES SHOULD WORK WITH THEIR LOCAL COMMUNITIES IN DEVELOPING COMBINED ACADEMIC AND SERVICE UNITS, WHERE APPROPRIATE, FOR THE PREPARATION OF HEALTH PROFESSIONALS FOR CAREERS IN PRIMARY CARE AND INITIATING THE APPROPRIATE COMMUNITY BASED HEALTH RESEARCH NECESSARY FOR THE EFFECTIVE UNDERSTANDING AND MANAGEMENT OF COMMUNITY HEALTH PROBLEMS.

7. THE PROGRAMS THAT HAVE BEEN DEVELOPED BY THE PROVINCE ALLOWING FOR THE INVOLVEMENT OF FACULTIES OF HEALTH SCIENCES WITH COMMUNITY GROUPS IN APPLIED AND OPERATIONAL HEALTH RESEARCH SHOULD BE PROVIDED THE NECESSARY SUPPORT TO ENSURE THAT THIS ARRANGEMENT IS EXTENDED TO ALL PARTS OF THE PROVINCE.

IV. RECOMMENDATIONS REGARDING CONSUMER NEEDS AND EQUITY

1. THE DISTRICT HEALTH COUNCIL, IN COLLABORATION WITH LOCAL PRIMARY CARE GROUPS, SHOULD ENSURE THAT THE LOCAL COMMUNITY IS AWARE OF THE VARIOUS HEALTH SERVICES AVAILABLE AND HOW TO ACCESS THEM.

2. THE DISTRICT HEALTH COUNCIL, TOGETHER WITH THE COMMUNITY INVOLVED, SHOULD BE ABLE TO IDENTIFY POPULATIONS AT RISK AND THEIR ABILITY TO ACCESS EXISTING HEALTH SERVICES.

3. THE DISTRICT HEALTH COUNCILS, WORKING WITH APPROPRIATE CONSUMER GROUPS SHOULD PLAN FOR THE DEVELOPMENT OF PRIMARY CARE SERVICES TO MEET THE NEEDS OF PARTICULAR POPULATION GROUPS.

V. RECOMMENDATION REGARDING ASSESSMENT AND EVALUATION

IN THE LONG-TERM, IT IS IMPORTANT THAT CONSIDERATION BE GIVEN TO DEVELOPING ASSESSMENT AND EVALUATION PROCEDURES FOR EVALUATING THE OVERALL PERFORMANCE OF PRIMARY HEALTH CARE SERVICES.

SUMMARY

1. The quality of human life in any community is influenced significantly by the available health care services. In addition, different population groups have different kinds and levels of health care need. Health care policies must, therefore, allow for a pluralistic health care delivery system to accommodate both population differences and differences among providers in terms of their preferred methods of service delivery.

2. A major issue in health care policy is how to ensure effective and efficient local health care planning and also involve the local community in the planning and decision-making process. Where they exist, District Health Councils are seen as playing a major role in developing local, commmunity-based, planning arrangements.

3. Another major issue in health care policy is funding and the overriding problem is the development of funding arrangements that can ensure that providers offer sensitive, high quality care efficiently to consumers of health services in a manner that is equitable and acceptable to all sectors of the population. Two important funding principles are: (a)

both the level of funding and the choice of provider payment mechanism should be appropriate for the population served and accommodate provider preferences; (b) the overall system of primary care funding should contain incentives for the efficient provision of effective services.

4. Provider arrangements for delivering primary health care range from solo practitioners to group practitioners, Health Service Organizations and Health Centres. A similar diversity exists among primary care funding mechanisms ranging from OHIP fee-for-service, capitation, budget and direct salary. Traditionally, specific provider arrangements have been linked to specific funding mechanisms, (e.g. solo practitioners and private practice groups to fee-for-service; Health Service Organizations to capitation and Health Centres to global budget). While these will probably continue to be the dominant funding patterns, there is, in reality, no rationale for linking specific delivery arrangements to specific funding mechanisms. In addition, it is believed desirable that Health Centres should be funded primarily through a program-based budget, instead of a salary plus overhead, formula-based budget. Funding of new Health Centres would be contingent upon: clear community support for the centre; a clear indication of consumer need or demand;

a clear description of the population to be served, and a clearly defined program that would meet the needs of the target population.

CHAPTER 3

ROLES IN PRIMARY HEALTH CARE

3.1 THE PROVISION OF PRIMARY CARE

Primary health care in Ontario has traditionally been provided in many locations and settings and through a variety of organizational arrangements such as solo physicians, groups of physicians, community health centres, Health Services Organizations, hospitals, public health departments, Northern nursing stations, voluntary and social agencies, the work place and schools. Professionals who work in primary care function on a care continuum from first contact and diagnosis through treatment, complete and continuous care and rehabilitation to referral and consultation. Also included in the professional functions are prevention, education, health promotion and maintenance.

The primary contact professionals, unless otherwise requested by the patient, are responsible for ensuring that the care continuum is carried out. The professionals responsible for co-ordinating or monitoring the program of care for a patient should ensure that other health professionals who see the patient from time to time fulfill their responsibilities. For high quality health care, sensitive to the needs of consumers, it is essential for primary care sector professionals to be concerned about the continuing health care needs of consumers. Consumers, for their part, have the right and responsibility to also participate in their own care.

Within the Health Centre concept, primary health care arrangements are provided by a group of health professionals, not necessarily all at the same physical site, who provide a range of services. These services include the basic clinical services provided by physicians and nurses, diagnostic services, specialized services, and other human support services provided by social workers, physiotherapists, occupational therapists, lawyers, nutritionists, podiatrists, psychologists, optometrists and others. When patients are referred to services outside the Centre, it is important that the Health Centre be informed and aware of the services provided by the referral group.

3.2 THE PROVIDERS

Because of the nature of primary health care services, the mix and number of health care providers in primary health care is diverse. One indication of this diversity has already been given in Chapter 2, Table

1. The effectiveness of a group providing primary care services depends on how well they can work together, their understanding and respect for each other's roles, their sensitivity to the needs of the individuals and the community which they serve, and the administrative arrangements.

Other factors that influence how well the groups can work together include:

1) Educational backgrounds;
2) Jurisdictional considerations and legal requirements; and
3) Professional attitudes.

Many different primary care health professionals already work together in various professional relationships, and a variety of potential alternate working arrangements have been suggested. There are, in a situation with such a diverse set of factors, many impediments to inter-professional relationships in these various settings and groupings.

It is natural for all health care professionals to strive for recognition and definition of their field of expertise. A field of knowledge can be best mastered if the content is well-defined and the boundaries are clear. Also, most health professionals enjoy the prestige of a separate and well-defined training program, a separate jurisdictional definition (possibly including licensing) and a separate professional association or associations. In the day-to-day work place, this differentiation may make it difficult for one professional to hand over responsibilities to someone else when the first individual feels that the responsibilities or functions which are being transferred are associated only with his/her profession. When new tasks are identified which fall outside any defined professional role there is a tendency for new professional groups to spring up which identify the gap, or for existing groups to expand their function to include the tasks as part of their expanded role. However, it must be recognized in some communities, one professional may have a multi-purpose role.

1) Educational Backgrounds:

With few exceptions, most health care providers who function at the primary care level, are educated in isolation from each other thereby preventing interaction with those other health providers with whom they will eventually be working. There are exceptions. For example, in some universities, with Health Sciences Faculties, integrated arrangements have been developed for some clinically based education programs. However, generally there is a tendency for health professional groups to establish their own curriculum, and define the content of their training programs without reference to related health professional education programs. Recently, there has been established in the province both at the community level and the university level, a complex planning requirement to try to address some of these issues, particularly the reasons for establishing new professional programs.

Despite these developments and the need for government approval to initiate and fund new programs, it has been difficult to achieve the kind of co-ordinated approach necessary towards professional training and education for individuals working in primary health care, particularly at the service delivery level.

Because of differences in student backgrounds and the specific needs of professional programs, it is obviously very difficult to provide common learning experiences for health professionals in the pre-clinical setting. However, at the applied level, there is evidence that programs can be developed where students receive at least a part of their training in association with students from other professional streams. The utilization of community health centres, Health Service Organizations and other group practice arrangements could make it possible to provide an expanded base for clinical education in a setting where mixes of professionals (e.g. medicine, nursing, social work, nutrition) are providing primary health care services.

To train students in these settings, it is essential that the funding arrangements not be an impediment to student placements. The existing arrangements for professional education in the primary care setting are not conducive to providing opportunities for a range of health professional students in community health centres or similar groups. If the desire to provide an opportunity for a common educational base in clinical settings is genuine, particularly for post graduate training, some consideration should be given to establishing support for all health professionals during this type of clinical training. Physicians have been supported by a government stipend for their post-graduate training which makes it possible for them to work in practice settings without substantial financial loss. Justification for this payment is partly related to the service they provide. The impact of trainees in primary care service delivery is significant. That is, in an ambulatory care setting, where a physician is on a fee-for-service arrangement, the supervision required by the trainee in the early stages reduces the amount of service the physician can provide. There has developed, therefore, a special program to fund clinical training in ambulatory care settings, geared to the stage of training at which the trainee functions during the placement. It would seem sensible to broaden the base of such funding to include other health professionals to be placed in similar settings which are not primary university teaching units. This would need a similar kind of financial support, both for the student and for the practice setting to ensure that the fiscal considerations do not act as an impediment to (a) attracting the students for training in these settings, and (b) the recruitment of appropriate, clinical training settings. In addition, the level of funding support should be kept commensurate with the rising costs of education.

The arrangements for providing opportunities for professional education in clinical settings can be diverse. Several examples already exist in the Province of flexible approaches that allow trainees to be placed in practice settings not controlled by universities. For example, the program in Northwest Ontario is an arrangement whereby Ontario physicians-in-training can take some of their training within the primary care and specialty practice arrangements that exist in that part of Ontario. The benefits of this program to both the professional groups and the students are well documented elsewhere (see, for example, reports of the Ontario Council of Health).

In addition, the Province has supported medical schools in their placement of primary care trainees in practice settings remote from the university. This support acknowledges that these practice settings are suitable for clinical training, and again, that they do not have to be primary university teaching units in order to serve this purpose. In many settings, these placements have provided unique opportunities for both the practice groups and the students and have been very successful. In developing funding arrangements to expand further the capacity for students with diverse backgrounds to train in these settings, it is essential to maintain the flexibility already established. This flexibility allows practice groups to decide whether they wish to take part in the program or not and does not make them dependent on the university for their income. By building on the existing philosophies of programs that have already been put in place, the government can promote flexible training arrangements with all the benefits to both the practice setting and the student.

2) Jurisdictional Considerations and Legal Requirements

Health Care professionals work under a variety of Acts and in some cases, under no recognized Act at all, e.g. Social Workers in Ontario. In reviewing the Acts that might affect Primary Health Care providers, we are aware of The Health Disciplines Act which covers five classes (medicine, dentistry, nursing, optometry and pharmacy). In addition, there is The Chiropody Act, The Ambulance Act, The Psychologists Registration Act and The Drugless Practitioners Act.

The regulations under which various health professionals work have different emphases in some cases. For example, The Health Disciplines Act is highly structured in its regulation and definition of various types of professional misconduct and contains elaborate appeal mechanisms for both practitioners and public, but does not address explicitly such things as delegation of medical acts. For example, there currently exists no regulation which allows the delegation of medical acts to nurses when, in fact, such delegation is occuring to some extent in both primary care and in institutional settings. The Health Disciplines Act allows for the development of regulations which would legally permit the delegation of medical acts to other health professionals, but no such regulations have been enacted.

Some health professionals are mandated to maintain certain ongoing credentials or educational goals; other groups are not. Some groups are bound by professional confidentiality and others are not. This can easily make one health professional reluctant to share his or her records with a health professional who is not bound by that same professional responsibility, which can result in each professional maintaining separate records for the same patient.

It can also result in some members of a professional group (e.g. family doctors) wishing to delegate a particular responsibility to another professional group (e.g. nurses) but the "receiving" group is not allowed legally to accept the added responsibility or new function. For example, many defined roles for primary care nurses, e.g. physicial examinations, cannot legally be delegated from the physicians to this nursing group.

While this results in a restriction on the flexible use of health care providers and may result in inefficiencies in an organization, it also provides a mechanism for consumer protection by maintaining accountability for medical acts. It is obviously important in any future developments that accountability for professional acts be clearly defined.

Any discussion of professional roles in primary care must take into account certain functions and requirements. Society has entrusted the power of labelling an individual's illness to physicians. In doing so, a variety of procedures have been established to ensure that this important function is carried out with accountability. Labelling, in terms of illness, is important for many reasons. It is essential, therefore, that the legal and accountability requirements be maintained and respected. It is also necessary that these requirements be reviewed from time to time to see if they need to be changed to allow for evolution of the system. Similarly, it is important that professional groups be sensitive to and appreciate the roles of, their colleagues and that working relationships facilitate the fulfillment of these roles.

Roles and functions that have been assumed during an evolutionary process by providers other than those originally mandated to perform them should be reviewed, and where appropriate, legitimized. The Health Disciplines Act does allow for appropriate delegation of roles among health professionals.

3) Professional Attitudes

Under this general category are professional needs for status, income, prestige and a defined area of responsibility. That is, there may be some tendency for professional groups to try to hold onto their areas of defined responsibility and to expand these, possibly at the expense of other groups, in order to improve the status of their own field. This competition may be quite subtle but can be a real barrier to a shared approach to providing primary care services by health professionals.

Another factor affecting attitudes concerns lines of professional accountability. As noted earlier, certain health professionals, notably doctors, have a legal accountability for the patient's wellbeing, while other health professional groups may not. This can affect their attitude towards a team approach to patient decision-making. Any organizational arrangement for primary health care services must, therefore, take into account the complex roles and legal requirements in trying to get the optimum co-ordination amongst all health care professionals for the provision of services.

It must also be recognized that someone ultimately has to carry the responsibility for medical decision-making. Every health professional within the system must understand and accept this. But non-medical decisions concerning patients are not necessarily the prerogative of physicians.

There will always be a range of attitudes. It is important to absorb and exploit the best of attitudes in the provision of services. If good professional standards are developed and maintained and different roles and functions legitimized, positive change in attitudes will be facilitated over time.

If educational programs can be developed which allow for professional training in primary care settings where team work is effective, it could have a major impact on the attitudinal question.

3.3 PROFESSIONAL ACCOUNTABILITY

Traditionally, each health professional is accountable for his/her practice to his or her own College or peer group. This provides accountability for care given to clients on an individual basis by each professional, with appropriate penalties for abuse, e.g. loss of license to practice, suspension or reprimand.

Organizations in health care on the other hand are made accountable for the care they give in different ways. The most accepted ways in Ontario are by accreditation and by the formation of Standards of Practice. Boards of organizations usually hold the legal responsibility for accountability, although, in the case of primary care settings where Boards exist (e.g. community health centres), the responsibilities are not clearly defined. Hospital Boards and the Boards of Health, on the other hand, which have long standing traditions in Ontario, operate under legislation which allows for accountability of their organizations.

Accountability in Ontario has taken a number of forms. In institutional settings with strong Boards and effective Professional or Medical Advisory Committees, there is not only the accreditation process in hospitals that results in periodic review of hospital performance but also the peer review function of the Medical Advisory Committee that monitors the quality of performance of each physician staff member. The effectiveness of these mechanisms is not solely dependent on the individual quality of the Board or Committee involved. If necessary, where standards are not being maintained, mechanisms are in place for action to be taken, either to replace the Board or to change the professional staff of the institution. In addition, there are professional programs run by the various colleges to try to ensure that professionals maintain high standards of performance. These programs vary in their applicability and only some are compulsory.

In the primary care sector, because there are seldom any formal institutional structures and no supportive legislation, peer review of performance is far more difficult to achieve. The College of Physicians and Surgeons of Ontario has initiated a random, compulsory peer review of office practices, about half of those practices being family physicians. From the standpoint of the public's interest, it would seem desirable that professional groups work to establish a strong peer review mechanism of all health professionals in the primary care setting. It should be noted that many group practices already operate under their own internal peer review system in order to maintain good performance standards.

The Task Force recognizes that the most effective way for primary care professionals to maintain standards is through their own professional review system. It is also important in the primary care sector that local groups should establish peer review mechanisms that take into account the complex issues involving professionals in that setting.

The setting up of Boards of community health centres is a possible arrangement for developing accountability for groups that have a number of providers delivering primary health care services. This can include arrangements for peer review of professional performance. If boards are established for groups providing primary health care services, they must take into account the respective professional roles in the provision of care. Such Boards would also do well to give consideration to how Hospital Boards fulfill their roles under The Public Hospitals Act but leave the professional responsibility for providing care to the Medical Advisory Committee. It is not useful if boards try to take on the professional's role in the provision of care.

Small community health centres may have their own professional Advisory Committees. However, it may not be productive for them to have a Community Board or Professional Advisory Committee due to their size and function. Nevertheless, we feel that all community health centres should function under the same basic standards.

RECOMMENDATIONS

We therefore recommend:

1) THAT THE CONCEPT OF ACCREDITATION, PEER REVIEW OF PROFESSIONALS AND THE DEVELOPMENT OF STANDARDS SHOULD BE EXTENDED TO ALL PRIMARY CARE SERVICES.

2) THAT THE MINISTRY OF HEALTH AND THE ASSOCIATION OF ONTARIO HEALTH CENTRES SHOULD WORK TOGETHER TO DEVELOP STANDARDS AND MECHANISMS FOR ACCREDITATION AND ACCOUNTABILITY FOR HEALTH SERVICE ORGANIZATIONS AND HEALTH CENTRES IN ONTARIO.

3) EDUCATIONAL PROGRAMS FOR PROFESSIONALS (E.G. PHYSICIANS AND NURSES) IN PRIMARY HEALTH CARE SHOULD BE ENCOURAGED TO DEVELOP COMMON EDUCATIONAL OBJECTIVES IN CLINICAL SETTINGS WHERE JOINT RESPONSIBILITY FOR THE PROVISION OF CARE CAN BE WORKED OUT.

4) WHERE CLINICAL EXPERIENCE IN A SERVICE DELIVERY SETTING IS DESIRABLE FOR THE PREPARATION OF HEALTH PROFESSIONALS IN PRIMARY CARE (FOR EXAMPLE, NURSES, SOCIAL WORKERS), IT IS RECOMMENDED THAT THE GOVERNMENT PROVIDE THE FUNDING ARRANGEMENTS FOR ALL HEALTH PROFESSIONALS, USING THE SAME PRINCIPLES THAT HAVE BEEN DEVELOPED FOR THE

SUPPORT OF PHYSICIANS TRAINING IN THE PRIMARY CARE SETTING.

5) IN ORDER TO FACILITATE STUDENTS BEING AWARE OF DIVERSE ARRANGEMENTS FOR THE PROVISION OF PRIMARY CARE SERVICES, THE MINISTRY OF HEALTH, THROUGH ITS FUNDING ARRANGEMENTS, SHOULD ENCOURAGE UNIVERSITIES AND COMMUNITY COLLEGES TO PROVIDE OPPORTUNITIES FOR STUDENTS TO SECURE SOME OF THEIR CLINICAL EXPERIENCE IN DIFFERENT KINDS OF PRIMARY CARE SETTINGS, INCLUDING HEALTH CENTRES AND HEALTH SERVICE ORGANIZATIONS

6) RESTRICTIVE CLAUSES IN HEALTH PROFESSIONAL LEGISLATION AND REGULATIONS BE REVIEWED PERIODICALLY WITH CONSIDERATION GIVEN TO REDUCING INEFFICIENCY WHILE STILL PROTECTING THE PUBLIC.

SUMMARY

1. The nature of primary health care services requires a diversity of health care providers.

2. For a diverse mix of health care providers to function effectively together, many impediments must be overcome. They include divergent educational backgrounds, professional legislation and regulations, and professional attitudes.

3. With regard to educational impediments, a coordinated approach towards the education and training of individuals working in primary health care is needed, especially at the service delivery level. A broader funding base which supports all health professional training in ambulatory care settings would help to overcome some of the educational barriers. Greater flexibility around choice of student practice settings would also be beneficial.

4. Primary health care providers work under a wide variety of professional regulations and legislation, designed both to maintain professional standards and accountability, as well as protect the public. These necessary

requirements may make role delegation, team approaches and coordination of services difficult. It seems especially important, therefore, to review periodically any restrictive clauses in health professional regulations and legislation. The aim would be to remove any unnecessary or outmoded clauses which impede efficiency or hinder inter-professional cooperation in primary health care settings, while still protecting the public.

5. Because primary care health professionals seldom work under any formal institutional structures, special efforts will be needed to develop professional standards and mechanisms for accreditation and accountability.

CONCLUSIONS

In reviewing the complex area of primary health care services, with special reference to Health Service Organizations and Health Centres, certain tentative conclusions and recommendations can be made at this stage.

1. In the opinion of this Task Force, it is the effectiveness of the primary health care services that will determine the future quality and efficiency of health care services in this province. The demands that will be placed on these services because of the changing characteristics of the population and the disease burden are clear.

2. The time available to allow individuals and groups to adjust the system to meet these new demands is limited. Failure to take the necessary steps now could make future adjustments, when the pressures are more severe, extremely difficult, and possibly lead to a health care system that cannot meet the objectives set out in the Health Charter for Canadians

3. Ontario has developed, through individual initiative and government policy, a variety of approaches to handling

the primary health care issues that could evolve into an effective approach to meeting future needs in this area. In particular, the arrangements that have developed for providing primary care services have taken into account the heterogeneous nature of the population and the varied delivery modes that are attractive to health care providers. One of the strengths of the Ontario system is this pluralistic approach to the provision of primary health care services.

4. As indicated in this Report, we have recognized the Health Service Organization and Health Centre development as part of the base for primary health care services that is important for developments now and in the future. The development of incentives for improved efficiency in primary care in relation to Health Service Organizations is important and should be applied to all groups providing primary health care services if we are to develop an efficient health care system.

5. We are impressed that some professional groups have begun to develop an understanding that changes are required if the issues discussed in this Report are to be resolved satisfactorily.

6. We are concerned that despite the recognition of the emerging issues in this area, the data base on which to judge the health status of the population and the kinds of services the population will need seems virtually non-existent. This makes it very difficult to plan for primary health care services and to assess the performance of the various arrangements and groups of providers of primary health care services.

7. The need for effective local planning for the development of primary care services is clear. It is essential, therefore, that clear guidelines be set out in relation to responsibilities for this and that local planning organizations, e.g. District Health Councils, be given the capability to see that this is done.

This Task Force has had to do its job in a limited time-frame and with insufficient information to address many of the larger issues that involve the whole primary health care field and its relation to secondary and tertiary health care. However, in terms of our specific task, we do believe that sufficient information and experience are available on which to base our recommendations and for the Government to proceed with their implementation.

We have based our recommendations on the concept that the arrangements for the provision of health care services should continue to evolve from the existing system base. The proposals of this Report are compatible with the introduction of a broader base of incentives for the provision of efficient, effective primary health care services. They are also compatible with the arrangements for the provision of health care services developing in a number of directions.

In considering this Report, there are two choices: (1) The Report and its recommendations can be acted upon as seems appropriate without further planning initiatives. (2) The Report's recommendations can be acted on as interim measures with the initiation of a more indepth review of the whole of primary health care services with recommendations for the future.

Among the issues that we were unable to address are the following:

a) what kind of overall incentive plan should be introduced to improve the efficiency of health care services in the primary and secondary care sector?

b) how does one continue to develop a decentralized system of care that is sensitive to the needs of individuals but within centralized public funding of health care services?

c) should there be integration of primary and secondary care services at the local level with both groups benefiting from their efforts to improve the efficiency of the system?

d) should there be bodies responsible for integrating primary and secondary health care services?

e) can a satisfactory data base, outlining the health status of the population, be developed against which we can assess need and the performance of the system?

f) what kinds of mix of health professionals do we require for the future, what should be their professional roles and how should they be educated?

In view of this, this Task Force recommends:

> THAT THE MINISTRY OF HEALTH ESTABLISH A TASK GROUP WITH THE LONG-TERM RESPONSIBILITY OF CONDUCTING A MUCH MORE IN-DEPTH REVIEW OF THE WHOLE PRIMARY CARE SECTOR, INCLUDING CONSIDERATION OF THE ABOVE POINTS AND BRINGING FORTH RECOMMENDATIONS FOR THE LONG-TERM DEVELOPMENT OF THE PRIMARY CARE SECTOR WITHIN THE CONTEXT OF THE ENTIRE HEALTH CARE SYSTEM

GLOSSARY OF TERMS USED IN PRIMARY HEALTH CARE SERVICES

ACCEPTABLE

Services are for people and must be given in an atmosphere and in ways which people understand and accept. Care must be taken not only to assure acceptability by the majority of people but also to assure that services for particular groups, such as the young, the aged, the poor, and people of different cultural backgrounds, are offered in imaginative and problem-centered ways.

In turn, services are provided by people - health professionals, other professionals, technologists, auxiliaries, and support personnel of many different types. They, too, have expectations and needs which must be recognized. The manner in which their skills and services are used will in large part determine not only their feelings of responsible involvement and work satisfaction but also the atmosphere in which the service is provided.

SOURCE: Hastings, J.E.F., The Community Health Centre in Canada, Vol 1, pp 1-10, Health and Welfare Canada, July 1972.

ACCESSIBLE

Health services must be not only available, but also accessible. People must be aware of the range of services that is available to them; and their voluntary use of such services and ease of entry into the health services system must be assured. Where necessary, transportation services should be developed to facilitate access.

SOURCE: Mustard, F.J., Report of the Health Planning Task Force, Ontario, 1974.

ADEQUACY/RANGE OF SERVICES

The health care system must encompass services for the physically ill and the mentally ill, and for individuals who are ambulatory and those who are not. Services are not limited to institutional care but include home care as well. They include the promotion of health and the prevention of disease, as well as the treatment of disease and rehabilitation. Part of the responsibility related to promotion and prevention lies in the health sector and part lies in other areas, such as education, recreation, housing and social services.

SOURCE: Mustard, F.J., Report of
the Health Planning Task Force,
Ontario, 1974.

AMBULATORY CARE INCENTIVE PROGRAM (ACIP)

Ambulatory Care Incentive Program provides an incentive payment to Health Service Organizations (paid by capitation) which have demonstrated a reduction in acute hospital utilization for their roster members when compared to a specified comparison population. The payment is provided monthly according to a formula as an incentive to augment ambulatory care programs or services which continue to reduce hospital days stay. If the hospital days stay of the roster population exceeds that of the comparison population in a given month, then no payment is made for that month.

SOURCE: Program Development Branch,
Ontario Ministry of Health.

AVAILABILITY

Health services must be available to all residents of the province, twenty-four hours a day, seven days a week, within the limitations imposed by types of health problems, resources and geographic factors. This does not mean that all services will be available in each community, but rather that they will be distributed throughout the province in proportion to the needs of the population to be served.

SOURCE: Mustard, F.J., Report of
the Health Planning Task Force,
Ontario, 1974.

CAPITATION PAYMENT

A dollar amount paid monthly for each eligible OHIP insured person enrolled in a Health Service Organization.

CAPITATION NEGATION

Capitation negation is an amount of money subtracted from the monthly capitation payment. The amount subtracted is based on the number of eligible enrollees who in a given month received insured health services from sources other than the Health Service Organization, despite the fact that the Health Service Organization had agreed to provide and be accountable for those services. The amount subtracted (negated) is equal to the payment which otherwise would have been made for those roster members in question.

SOURCE: Health Service Organization Procedures Manual, Ontario Ministry of Health, Program Development Branch, 1982.

COMMUNITY HEALTH CENTRE

A community health centre is defined in the Hastings' study as "a facility, or intimately linked group of facilities, enabling individuals and families to obtain initial and continuing health care of high quality. Such care must be provided in an acceptable manner through a team of health professionals and other personnel working in an accessible and well-managed setting. The community health centre must form part of a responsive and accountable health services system. In turn, the health services must be closely and effectively co-ordinated with the social and related services to help individuals, families, and communities deal with the many-sided problems of living.

A community health centre is an organization and service concept, a financial and administrative integration of resources to help people to deal humanely and rationally with one another in receiving and providing health services. It recognizes and gives form to the dynamic interaction necessary between the helper and the helped. It promotes personal and community responsibility.

SOURCE: Hastings, J.E.F., The Community Health Centre in Canada, Vol 1, pp 1-10, Health and Welfare Canada, July 1972.

DISTRICT HEALTH COUNCIL

District Health Councils have been established in Ontario to advise the Minister of Health on the planning and development of an integrated system of health care services in each area of the province.

The District Health Council is a way in which the people of a community have a voice in identifying the need for, and planning the provision of, local health services.

While a District Health Council has no direct control over health services in its area, it does have responsibility for (1) objectively assessing community needs; (2) planning a co-ordinated health care system to meet those needs; and (3) advising the Minister of Health as to the specific changes required in the community to implement its plans.

Because changes are always taking place in a community and because of the complexity of the system, the assessing/planning/advising role of the District Health Council becomes a continuing process.

A Council usually consists of 15 to 19 members, with one-third of the members appointed for a one-year term, one-third for two years and one-third for three years. This permits renewal of one-third of the members each year. An individual may serve a maximum of two three-year terms.

Since the primary role of a District Health Council is to involve the community in health care planning, it is vital that consumers of health care be included in the make-up of the Council. Providers of health care should also be on the Council and most Councils include representatives of local government as well. The suggested "mix" is consumers 40 percent, providers 40 percent and local government representation 20 percent.

SOURCE: Ontario Ministry of
Health: District Health Council
Program

EFFICACY/EFFECTIVENESS/EFFICIENCY

Efficacy: the benefit or utility to the individual of the services, treatment regimen, drug, preventive or control measure advocated or applied.

Effectiveness/Efficiency: the essential difference between the terms is that effectiveness is related to the results achieved (or planned to be achieved) and efficiency to the cost, in terms of resources, of achieving those results. The latter term approaches the meaning of the technical term cost-effectiveness (q.v.).

Effectiveness: the effect of the activity and the end-results, outcomes or benefits for the population achieved in relation to the stated objectives.

Efficiency: the effects or end-results achieved in relation to the effort expended in terms of money, resources and time.

SOURCE: 14th Report of WHO Expert Committee on Health Statistics, TRS 472, 1971, p. 11.

EVALUATION

Evaluation of Health Services: the systematic and scientific process of determining the extent to which an action or sets of actions were successful in the achievement of predetermined objectives. It involves measurement of adequacy, effectiveness and efficiency of health services. It renders possible the reallocation of priorities and resources on the basis of changing health needs.

SOURCE: Clarification and Working Definition of Health Services Functions and Terminology, Appendix to Resolutions of WHO Executive Board, 51st Session, 1973, Official Records of WHO, No. 206, p. 114

GROUP PRACTICE

See Primary Care Group.

HEALTH CARE

Health Care

Health care aims at the health protection of the population of a given area and at maintaining and improving the health status of that population. It is concerned with the promotion of health - not only physical health (including dental health and physical fitness) but mental health. It is also, in consequence, concerned with sickness or morbidity (both acute and chronic disease); and, inevitably, with mortality. It extends from the cradle to the grave, from maternity care to geriatrics and the problems of old age; indeed it begins earlier than the cradle, with family planning and with the consideration of fertility and infertility. Health care embraces caring for people when they are ill, nursing care, dental care and many associated forms of care.

SOURCE: Adapted from WHO, Glossary of Health Care Terminology, Geneva, 1978.

HEALTH SERVICE ORGANIZATION

The Health Service Organization Project within the Ontario Ministry of Health administers two alternative payment programs for funding of primary health care services, (the Health Service Oorganization and the Health Centre) other than those provided on a fee-for-service basis.

A Health Service Organization is an administrative label that the Ontario Ministry of Health has designated for primary health care delivered by organizations ranging from physician partnerships to those resembling the Hastings Community Health Centre model where funding is provided to the organization on a capitation basis for specified contracted health services to a rostered population. Capitation payments are based on the size and age/sex mix of rosters, the rostered members of are OHIP insured and voluntarily enrolled. In addition, the contract provides for "capitation negation". (See definition elsewhere in this Glossary.)

An Health Service Organization is also entitled to receive an Ambulatory Care Incentive Payment (ACIP) when it is determined that its in-patient hospital utilization is lower than that of a designated comparative district. (See elsewhere in this Glossary for a definition of ACIP.)

A Health Centre is an administrative label that the Ontario Ministry of Health has designated for community-based organizations which receive a global budget based on an approved complement of physician and nurse practitioner staff for providing primary care to an identified population. Health Centres in the past have ranged from solo physician practices to the full multi-service centre resembling Hastings' model of the community health centre.

MULTI-SERVICE CENTRE

This is an administrative and operational term used by the Ontario Ministry of Community and Social Services. In our Report, this type of organization is included under the definition of a "community health centre" and is referenced here when health services are among the package of services offered.

NEED/DEMAND

Need

A state of health assessed as in need of treatment by a health professional.

Demand

Those individual consumer wants that the individual converts into a demand by seeking the assistance of a health professional.

SOURCE: Adapted from Cooper, M.H. "Rationing and Financing Health Care Resources" in N. Hunt and W.D. Reekie (eds.) Management and the Social Services. London, Tavistock Press, 1973.

PLANNING

Policy choice and programming in the light of facts, projections, and the application of values.

SOURCE: A.J. Kahn, The Theory and Practice of Social Planning. New York: Russell Sage Foundation, 1969, p. 17.

PREVENTION

Primary Prevention: All measures designed to reduce the incidence of disease in a population, by reducing the risk of onset. This corresponds roughly to the traditional concept of prevention.

Secondary Prevention: All measures designed to reduce the prevalence of disease in a population, by shortening its course and duration. This takes in some aspects of treatment.

Tertiary Prevention: All measures designed to reduce the prevalence of chronic disability in a population, by minimizing the functional impairment consequent to disease. This extends the concept of prevention into the field of rehabilitation.

SOURCE: Report of WHO Conference on Public Health Training of General Practitioners, TRS 140, 1957, p. 6.

PRIMARY CARE GROUP

The primary care group can be described organizationally as a number of health and allied professionals grouped together to meet primary health needs in a given geographic area on a continuous (24-hour) basis. The organizational grouping does not necessarily imply a common physical location, but it should make possible a more effective utilization of the skills of health professionals within the group and provide for a range of health services that are available, accessible and continuous.

SOURCE: Mustard, F.J., Report of the Health Planning Task Force, Ontario, 1974.

PRIMARY HEALTH AND SOCIAL SERVICES

Primary Health and Social Services provide essential health care. They are universally accessible to individuals and families in the community by means acceptable to them, through their full participation and at a cost that the community and country can afford. They form an integral part both of the country's health system of which it is the nucleus and of the overall social and economic development of the community.

SOURCE: Adapted from the International Conference on Primary Health Care, Alma Ata, USSR, 6-12 September, 1978.

PRIMARY HEALTH CARE SERVICES

Primary health care services include not only those services that are provided at first contact between the patient and the health professional, but also responsibility for promotion and maintenance of health and for complete and continuous care for the individual, including referral when required. As our previous comments indicate, we are convinced that primary care can be provided most effectively through group arrangements.

SOURCE: Adapted from Mustard, F.J., Report of the Health Planning Task Force, Ontario, 1974.

ROSTER

A list of voluntary enrolled patients of a Health Service Organization who have identified that Health Service Organization as their source of care for services which the Health Service Organization has agreed to provide, and acknowledged such to the Ministry of Health by signing an enrolment form. The Health Service Organization is paid by the Ministry of Health based on the signed roster.

SOURCE: Program Development Branch, Ontario Ministry of Health.

APPENDIX "A"

Memorandum on Health Centre Funding

Working Paper prepared for
members of the Minister's
Task Force to Review the
Primary Health Care Sector

by G. L. Stoddart

October 11, 1982

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Memorandum on Health Centre Funding

The purpose of this memo is to explore and make recommendations on methods of funding health centres (HC's) and health service organizations (HSO's). This is provided in part three, where four specific policy options for funding within health centres are discussed and a proposal made for programmatic funding across health centres, health service organizations and fee-for-service practitioners. Parts one and two of the memo provide important background to the analysis and proposal. In part one I suggest principles to be included in any funding policy for the primary care sector. Part one also presents a framework for discussion of policy development based on these principles. Part two is an attempt to distill and present key issues from past and current dialogues between the Ministry of Health Program Development Branch and the HC's/HSO's on the subjects of funding and accountability. Finally, part four identifies further important issues which were precluded from development by constraints of space and time.

1. Toward A Conceptual Framework For Policy Development In the Funding of Primary Health Care

Considerable discussion often occurs over the funding "rationale" for organizational innovations in primary care. It seems important, therefore, to indicate at the outset that there is presently no articulated rationale for the existing system of primary care funding, with its heavy reliance on solo, fee-for-service physicians. Presumably, the unarticulated rationale is that this modality existed prior to public health insurance and was (and continues to be) acceptable to most physicians and patients. While this is certainly one good reason to retain fee-for-service as one funding modality in any future system, it provides little guidance as to the principles which might underpin a funding policy for primary care.

A comprehensive set of funding principles is beyond the scope of this memo; however, it does seem possible to suggest two principles to be used as cornerstones:

i) Both the level of funding and the choice of provider reimbursement mechanism should be appropriate for and determined by the characteristics of the population served, and

ii) The overall system of primary care funding should contain incentives for efficient provision of effective services.

Ideally, in a health care system such as the Ontario one, which attempts to distribute services on the basis of need, three factors should determine the cost of the primary care sector. These are the health status of the population, the existence of effective health services including preventive services, and society's collective willingness to pay for care. In actual fact, the way in which services are organized and providers are remunerated becomes almost as important a determinant of cost as the first three. There are both low and high cost styles of meeting the health needs of any given population. More important, there are diverse groups of varying sizes within the population, exhibiting different socioeconomic status, risk status, age and sex distribution, etc. and therefore having different health needs.

No one method of organizing and funding health services is therefore likely to be suitable in all situations. Pluralism is required. More specifically, no one method of remunerating providers is free of adverse incentives on cost or quality. A brief examination of the incentives or disincentives for efficiency that are inherent in each of the three most common remuneration methods (fee-for-service, capitation, and salary) will illustrate this. Let us first distinguish two types of efficiency that we are most interested in, "technical" efficiency and "allocative" efficiency. To assess technical efficiency we ask the question "Are we producing a specific service or procedure (e.g. well baby exam) with the least use of resources?" To assess allocative efficiency we ask a broader question, namely "Are we producing the proper mix of services and the proper amounts of each service?" In otherwords, we can be producing a specific service in a technically efficient manner but be over or under producing it, considering its impact on health status either in an absolute sense or relative to other service opportunities within a fixed resource pool.

Both fee-for-service and capitation are expected, other things being equal, to impart incentives to individual providers for technical efficiency in the provision of specific services within their own practices, since minimizing costs in the face of a fixed fee or capitation payment contributes directly to net income. However, neither method in theory performs as well against the allocative efficiency criterion. Fee-for-service encourages overservicing, a phenomenon well documented in the health services research literature. Conversely, critics of capitation correctly point out that it encourages underservicing. There is no solid evidence of this in the literature I am familiar with; however, absence of proof should not be taken for proof of absence. The third remuneration method, salary, inherently possesses no incentives for either technical or allocative efficiency.

This obviously does not constitute a thorough analysis of these remuneration methods. Much depends on the framework of institutional mechanisms, peer review, and the orientations of individual practitioners. Furthermore, the fact that a particular mechanism encourages efficiency does not guarantee its attainment. Similarly, the absence of any inherent efficiency incentives does not preclude efficient provision, especially if providers are sensitive to the resource implications of their practice style. Moreover, this discussion relates to the remuneration of providers rather than practices or organizations. It is entirely possible for payment methods to be different at the two levels.

The key point is that there are a limited number of funding methods, and none, by itself, possesses the necessary incentives to ensure efficient provision of effective primary care. However, to the extent that a variety of models of organization and funding exist, there is the potential for constructive tension among the models to enhance both the technical and allocative efficiency of the overall system.

It may be helpful in considering methods of funding primary care to represent the matching of health services to population groups in a matrix, as in Figure 1. The rows of the matrix represent three categories of the population, based on health needs. One could imagine further and finer breakdowns, but this one seems relevant to the current Task Force. The bottom row represents that part of the population seen to be "typical" or "average" in its collective health needs, based on socio-demographic and

Figure 1 What Funding Methods Must Assist in Accomplishing: The Linkage of Primary Care Services to Populations' Health Needs in an Effective and Efficient Manner

		TYPE OF PRIMARY HEALTH CARE SERVICE OR PROGRAM				
		Medical Services	Health Promotion/ Illness Prevention	Counselling	Legal Assistance	Housing Assistance
TYPE OF POPULATION	High Risk: poor aged chronic care mentally ill					
	Atypical: special needs, but not high risk					
	Typical	*				

socio-economic characteristics. The middle row represents that part of the population which has atypical health needs, but which is not high risk under the terms of reference of this Task Force. A good example of such a population sub-group might be workers in a relatively prosperous mining town who have specific occupational health needs. The top row represents that part of the population considered to be high risk, i.e. the poor, the aged, and those with mental health or chronic care problems.

The columns of the matrix designate the different types of services or programs which comprise the primary care delivery spectrum, ranging from traditional medical services through illness prevention/health promotion activities and on to counselling and other services aimed at important social needs. The list is far from complete, but is meant to be illustrative of the range of services.

This matrix raises a variety of policy relevant questions. How great is the need in each cell of the matrix? To what extent do current models of primary care provision meet these needs? What funding mechanism(s) is (are) most appropriate for each cell or combination of cells? These, and questions other readers will pose, do not yield to simple answers. The matrix is, however, a stimulus to thought. Furthermore, it allows us to make several observations relevant to the deliberations of the current Task Force.

First, with some oversimplification it seems possible to characterize the existing fee-for-service system as covering "only" the lower left hand cell of the matrix, marked with an asterisk. This is not to claim that anything else is beyond its capabilities ---- indeed, revision of benefit schedules to encourage different practice styles is clearly one policy option ---- but merely to suggest that its impact to date has likely been primarily in one (albeit large) cell of the matrix.

Second, the matrix clearly illustrates what a methodologically valid comparison of the performance of fee-for-service models and HSO/HC models would entail. In a fully developed state, HSO's/HC's might cover the entire matrix. At the present time, the degree of coverage varies considerably across the HSO/HC network. However, in principle, one would like to compare the fee-for-service and HSO/HC models on two dimensions: i) the full social cost of the utilization of all primary care services in the matrix, and ii) impact on health status. This is a rather formidable research task, perhaps an empirically impossible one. Nevertheless, it seems fair to suggest that past studies in Ontario have generally not been able to isolate for comparison similar populations receiving similar services.

Third, and perhaps most important, the matrix makes it easier to visualize opportunities for a flexible and pluralistic funding policy, since there is no presumption that only one funding mechanism is appropriate for any cell. Nor, for that matter, is there any presumption that a specific provider (or group) should have to receive his (their) entire remuneration via one method. HSO's currently receive some fee-for-service income in addition to capitation funding, because fee-for-service is the more appropriate mechanism for certain types of patients. Perhaps HSO's should be eligible for global funding to launch programs beyond medical services and health promotion activities or other programs for groups of patients with special needs. Moreover, perhaps fee-for-service practitioners should be eligible for special program funding to provide an occupational health service in a justifiable circumstance, or to hire a nurse practitioner in another. Perhaps HC's should be eligible to declare a proportion of their population appropriate for capitation and register them, retaining a global budget for the remainder or for special programs. If nothing else, it is hoped that a matrix representation opens some thought channels for more creative thinking on a funding policy for primary care.

The principles and concepts introduced in this section are refined into a more specific proposal following a review of current key issues in HSO/HC funding and accountability.

2. A Selective Review of Issues in Funding and Accountability

2.1 The Community Health Centre (CHC) Spectrum

At the present time, policy development appears difficult at least partly because there is no programmatic separation of capitation-funded organizations (labelled HSO's by the Ministry) from globally-budgeted organizations (labelled HC's). In my opinion, the nature of key funding/accountability issues in globally-budgeted centres is different from that in capitation-funded centres. The dialogue between the HSO's/HC's and the Ministry seems to have been further blurred by the insistence of some HSO's and HC's that they are in fact the same animal, even though they are fed differently!

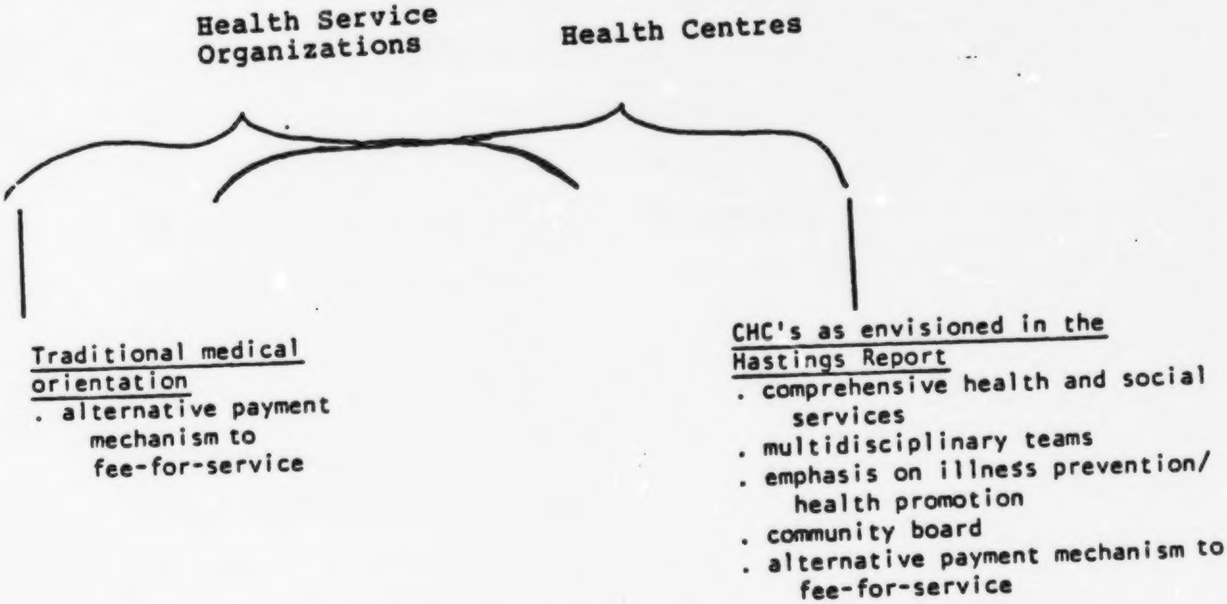
It would clarify the situation substantially, I think, if the organizations currently comprising the HSO/HC network were viewed as falling along a spectrum, called the Community Health Centre Spectrum, illustrated in Figure 2. Centres would then be differentiated according to the degree to which they met the Hastings Report conception of a CHC. The Hastings criteria are not untouchable. Some updated or revised criteria might be developed. The important point is that centres would be differentiated by their orientation to primary care rather than their funding method. In fact, multiple funding methods might be used at almost any point on the spectrum, depending upon the size and characteristics of the population served.

The spectrum reflects the two main origins of centres currently in the HSO/HC network. At one end are those centres with a traditional medical orientation to primary care, but whose physicians prefer to be paid on a basis other than fee-for-service. At the other end are centres with a community-based primary care orientation and a fully developed range of health and social service programs, under the control of a community board. If the terms "HSO" and "HC" are used to refer solely to funding mechanism, it is entirely possible for both existing and future centres that are apparently "different" (by label) to be quite similar in their goals and orientation. Likewise it is and will continue to be possible for centres with different orientations to be considered similar because they share the same funding label.

The failure to clearly recognize the fundamentally different orientation of organizations toward the right-hand edge of the Community

FIGURE 2

The Community Health Centre Spectrum



Health Service Organizations

Health Centres

Traditional medical orientation
- alternative payment mechanism to fee-for-service

CHC's as envisioned in the Hastings Report
- comprehensive health and social services
- multidisciplinary teams
- emphasis on illness prevention/ health promotion
- community board
- alternative payment mechanism to fee-for-service

Health Centre Spectrum may partially account for the lack of policy success in moving HC's onto capitation. The strategy of providing global budgets as an interim measure until HC's grow into viable capitation organizations appears to have stalled, and may need to be rethought. While sheer size is often cited as the obstacle, the effect of size alone is confounded with and exacerbated by the attempt to execute a community-based orientation from a capitation rate based on the traditional medical orientation of the fee-for-service sector. This type of rate may be entirely appropriate for organizations toward the left-hand edge of the CHC Spectrum; however, it is unlikely to provide sufficient resources for centres further along the Spectrum. Thus the strong support of existing HC's for continuing global budgets or a significantly revised capitation formula is quite understandable.

Before considering in more detail the funding rationale for the ends of the CHC Spectrum, the nature of the funding/accountability dialogue is briefly summarized separately for capitation and globally-budgeted organizations.

2.2 Capitation Funding: A Need for Fine-Tuning and Development

Capitation funding as applied to the HSO program is a total dollar amount paid monthly for all eligible OHIP insured persons who have enrolled in the HSO. Capitation-negation is the term used to describe an amount of money subtracted from the monthly capitation payment based on the number of eligible enrollees in a given month who received health services from sources other than the HSO, despite the fact that the HSO agreed to provide and be accountable for those services. The amount subtracted (negated) is equal to the payment which otherwise would have been made for those roster members in question.

Among the centres currently funded on a capitation basis there appears to be satisfaction with the concept of capitation and the mechanism of capitation-negation; however there is considerable dissatisfaction with the specific capitation formula presently employed. The main criticisms of this formula are:

1. It does not take into account the "burden of illness" of the population served, i.e. to the extent that the population served differs on dimensions other than age and sex from the general Ontario population on which the capitation rate is based, the rate under (or over) funds the centre. For example, if a centre's population is "poorer and sicker" than average, it deserves a higher than average rate.
2. In calculating the capitation rate, (i.e. the age-sex adjusted average cost per capita of provincially insured medical services) it is inconsistent to include the HSO/HC population in the denominator but to exclude the HSO/HC costs from the numerator. This biases the rate downwards.
3. In calculating the capitation rate, the denominator should be the insured population rather than the census population. Since the former is less than the latter, use of the latter again lowers the rate. Although the difference between the insured and census populations may be quite small (e.g. 1-3%), it may have a significant impact on a centre with a large patient population.

The Ambulatory Care Incentive Program (ACIP) provides an incentive payment to HSO's which have demonstrated a reduction in hospital utilization for their members compared to a specified comparison population. The payment is provided as an incentive to augment ambulatory care programs or services which contribute to reduced hospital days of stay. The monthly ACIP payment is currently calculated by multiplying the difference (where positive) in days stay per thousand population between the comparison population and the HSO roster by one-third of at least five year old comparison district hospital per diem.

The following major concerns have been raised with respect to the Ambulatory Care Incentive Program:

4. The comparison population needs to be refined such that the calculation is age-sex adjusted and the comparison reflects the hospital experience of the population of only the community in which the practice is based.

5. The calculation of the ACIP payment should employ the most current figures available on per diem hospital costs.

6. The determination of the proportion of "savings" to be returned is arbitrary and should be higher than the current one third.

Several criticisms of the administration of the capitation funding arrangements have also been made:

7. Capitation negation information is both late (up to 8 months) and insufficient for management purposes. Without violating confidentiality it should be possible to report back greater information which would assist practices in their management.

8. Capitation payments are not updated quickly enough for changes in the OHIP Benefit Schedule, either for new services or new benefit levels.

Finally, concern has been expressed that appropriate allowance is not made for program development within capitation funding:

9. Because the capitation rate is based solely on medical service equivalents in the fee-for-service sector, there is insufficient scope to develop additional primary care programs or services, especially where initial capital outlays or learning periods may be involved.

Although this list of issues is lengthy, it is typical of the evolution of any innovative funding program. It takes time for the refinement of specifics. Note, however, that it is only the level of funding that is under dispute and not the appropriateness of capitation as a mechanism. The financial impact of these potential refinements will not be trivial. Preliminary calculations for Sault Ste. Marie suggest that acting on points 2,3,5 and 8 alone would increase this budget by more than 10%.

With respect to the nine issues, above points 2,3,4,5 and 8 would seem to be well-taken and feasible to revise, although the specific revisions would need to be carefully worked through by Ministry staff. The others, which also seem to be well-taken, are more problematic. While it is in principle fair to adjust capitation rates for characteristics of the population served other than age and sex (point 1), especially health status, the feasibility of this is doubtful. No adequate and easily accessible measure of health status exists, and proxy measures such as socio-economic status (based on the positive correlation between illness and low income) will likely be difficult and/or costly to monitor accurately. Although we are primarily concerned here with HSO's, this conclusion is significant for HC's as well. If no other gross adjustment mechanism can be found, some HC's not currently on capitation may never be capitation viable even if significant roster development takes place.

The appropriate proportion of hospital savings to be returned under ACIP (point 6) raises a different problem. In this case, while any proportion will be of necessity an arbitrary determination, the real problem is that there is no integration of primary and secondary care, either within the HSO program or across the HSO and fee-for-service sectors. Thus, if beds emptied by HSO's reacting to ACIP incentives are filled by fee-for-service physicians in the community, ACIP payments are quite correctly viewed by the Ministry as an add-on. But this is obviously not the fault of individual HSO's. Until either accountability is established to the Ministry for hospitalization patterns in the fee-for-service sector or incentives are provided for patients to choose between the two sectors at least partly on the basis of efficient use of resources (including hospitals) it will be difficult to reward HSO's appropriately for decreased hospitalization.

Points 7 on capitation negation information, and 9 on development funds, remain. With respect to the former, I am unclear as to the extent of confidentiality concern; however, this is an issue which deserves follow-up and resolution subsequent to the Task Force. With respect to the latter, it does seem desirable for practices wishing to move along the CHC spectrum to be given some consideration beyond the capitation rate based on medical service equivalents. Discussion of how this might be accomplished is postponed to sub-section 3.3 below.

The subject of HSO accountability to the Ministry in demonstrating value for money is one which has often been raised in the past. Concern has arisen over i) the accuracy of the population roster on which payment is based, ii) documentation that populations have in fact received services of the nature and level implied in the capitation contract, and iii) the income levels of physicians receiving their income directly from capitation relative to those of fee-for-service physicians.

On the basis of materials submitted to the Task Force by the Program

Development Branch of the Ministry it would appear that recent roster verification exercises and initiation of an encounter form data system should, when complete and debugged, address the first two concerns. (In this regard, it is unfortunate that the time constraints facing the Task Force will not allow a review of the initial processing of encounter data).

The third concern may be interpreted in two ways, depending upon what one believes about service provision and health status in the capitation population. On the one hand, the concern may be that the level or type of service provided by the capitation practice is inadequate for the health needs of the population and does not meet the standards implicit in the capitation payment, thus provider incomes are "too high". This is of course a serious cause for concern, but one which may be extremely difficult to document, especially given the imprecision of health status measurements. Some evaluation of the process of care, perhaps through the use of tracer conditions, may be the best accounting possible. On the other hand, if the source of concern is not servicing patterns or health status but rather the observation of higher incomes per se on capitation than would otherwise have occurred on fee-for-service, this is surely an issue of accountability for fee-for-service physicians instead of those on capitation. The observed income difference in the face of equivalent population health status presumably reflects overservicing among fee-for-service physicians on whose performance the capitation rate is based.

2.3 Health Centres and Global Budgets: Questions of Legitimacy and Survival

The funding/accountability issues in the ten globally-budgeted Health

Centres appear to be of a fundamentally different nature than those just identified for the seventeen Health Service Organizations. The three main areas of concern for HC's are:

1. The HC's quite obviously, and not without reason, feel extremely insecure. Without ongoing program status, these HC's face repeated uncertainty over the renewal of contracts, and the terms of renewal. Such an atmosphere makes longer term planning difficult and diverts the energies of staff from program development.

2. The appropriateness of the global budget itself as a funding mechanism is in question. The current global budget is personnel-based, paying salary plus overhead for an approved complement of staff. This mechanism was intended to be only an interim measure until the HC's developed rosters which would make capitation viable; however roster development has proceeded slowly in general, despite the strong efforts of some centres, and it seems clear that some HC's will never be capitation viable.

Since the Task Force has received submissions from only two HC's at the time of this writing, it is difficult to comment on the feelings of the centres. However, there does not appear to be any general agreement on a preferred "solution". Some centres (such as York) apparently favour retention of global budgets (with revisions noted below) while others (such as Centretown) propose a significantly revised capitation system.

The major problem with current global budgets appears to be that, since they do not involve the identification of a population (nor for that matter, specific programs which would allow management by objectives to occur for specific client groups), it is difficult to establish accountability to the funding source. Centres are accountable to community boards for service delivery, however it is extremely difficult under the salary plus overhead type of global budget to document value for money.

The special nature of many HC patient populations, with high numbers of transients and/or ineligibles, individuals uncomfortable with or hostile toward bureaucracy, and families with special needs also affects the choice of funding mechanism. These factors not only make enrolment a costly and ineffective exercise for some proportion of the centre's population, thus undermining capitation, they also result in significant amounts of "outside use". This phenomenon further weakens capitation, but it also affects global budgets since it creates situations in which government feels it is "paying double" for some individuals. In fact, the nature of HC's patient populations and the multi-service, community orientation of the centres are the key issues which any new funding rationale for the centres will have to address.

3. Within the context of existing global budget arrangements, revisions have been suggested to improve the funding level for HC's. These revisions are summarized in the submission from York Community Services entitled "Recommended Changes to Global Funding

Formula." The main criticisms of the current arrangement relate to the overhead allowances. It is suggested that: i) overhead funds should not fluctuate with physician's salary and experience since this can create problems when physician turnover occurs, ii) overheads should be provided for all nurse practitioners, and iii) overheads should be increased to accommodate costs other than the administration of physician and nurse practitioner activities. While these suggestions do not appear unreasonable, the problem again arises that without program objectives and descriptions (including staff allocations) it is not at all obvious how much overheads should be revised. A second concern about funding level, parallelling that of the HSO's, is that special monies for program development (in particular health promotion programs) do not exist.

2.4 The Funding Rationale(s) for the CHC Spectrum

Throughout most of the development history of the HSO/HC network, the main funding rationale for these alternative models of delivering primary care has been that they expand choices to both providers and patients, with equivalent quality of care, while costing no more than the provision of services would have under the fee-for-service model. If the fee-for-service system is accepted as a baseline (or if political constraints force its use as a baseline), then this rationale may be appropriate for the left-hand edge of the CHC Spectrum in Figure 2. At this end, primary care means primary medical care, provided with a traditional medical orientation. Practices providing such care are on the Spectrum only because their method of payment is other than fee-for-service.

The historical funding rationale becomes progressively less appropriate, however, as one moves along the CHC Spectrum to the right-hand edge. Not surprisingly, it is or will be difficult for most centres at this edge to maintain services consistent with their orientation to primary care, which in this case means primary health care, while remaining within the rationale. But if not the historical funding rationale, then what? There appear to be three potential candidates: a broader economic rationale, a quality of care rationale, and a social equity rationale.

An economic rationale broader than the old one would justify centres on the basis of a decreased total resource commitment to primary health care compared to that which occurs under the combination of fee-for-service medical care and fragmented provision of the remaining health and human services. This could stem from decreased medical and hospital costs through both more emphasis on illness prevention/health promotion and less emphasis on institutionalization. Indeed, some HC's and most HSO's along the CHC Spectrum have decreased rates of acute hospitalization compared to the fee-for-service sector.

It is misleading (and perhaps unstrategic) however, to attempt to base the funding of these centres on deinstitutionalization for two reasons. First, the hospitalization savings (net of ACIP payments) would not likely be able to finance indefinitely the extended range of health and social service programs that the centres wish to provide. Second, as indicated earlier, unless accountability is established in the fee-for-service sector, the system as a whole is still open-ended and no net saving is realized.

A lower total resource commitment to primary health care might also stem from lower health and social service costs other than medical and hospital care. This may be the result of better program planning or more efficient multiple service coordination than that which occurs in the unorganized "system" which patients of fee-for-service practitioners must access. The main difficulty with forwarding this as the rationale is that it is not testable without a considerable investment in evaluative studies, the feasibility of which is not assured. A comparative study of the full social costs in the two sectors would be a valuable contribution to the ultimate development of primary health care policy. But it would not be available tomorrow. Moreover, such a study might well show higher total costs in the CHC Spectrum centres, even on a standardized population basis, simply because equivalent health and social services/programs either do not exist or are not as easily accessed for the patients of fee-for-service physicians. Thus it would be necessary, as in all economic assessments, to examine outcomes (i.e. health status) before reaching any conclusions regarding value for money. Furthermore, even if a study showed lower total costs for CHC Spectrum centres, we are talking about social costs. Since many of the services used by fee-for-service sector patients would be privately financed, it would almost certainly be the case that publicly financed costs (and especially Ministry of Health costs) would be higher. The broader economic rationale thus appears fraught with blind (or at least uncertain) alleys.

A second avenue for a new rationale might proceed on the grounds that although costs (however defined) might be higher in the Spectrum centres, quality of care is (at least) proportionally higher as well. Given the difficulty of measuring quality in an outcome sense, and the emotional responses which allegations of higher (and by implication lower) quality usually trigger, this must indeed be considered a courageous/foolhardy approach to a new rationale. There is evidence in the literature to suggest that centres adopting a community-based approach provide no worse, and in many cases, slightly better quality care as judged by process measures. But it is a long jump from a few comparisons to a policy rationale for an entire sector, especially given the heterogenous nature of existing health centres.

The most promising, and appropriate, rationale is one of social equity. This rationale recognizes that there are particular population groups who have special health needs that exceed those in the general population, and accepts the normative proposition that more should be spent on servicing these groups. It also recognizes that there is a conflict between the achievement of average per capita cost targets on the one hand and the humane provision of health services, often but not always to high risk groups, on the other. The contribution of the caring function to population health status is almost impossible to measure. But again, absence of proof is not proof of absence. Few will deny that there is an epidemiology of not being cared for, although we understand little about it. To an observer of the development of health centres, the ability to perform the caring function in a comprehensive and innovative manner is one of their most striking features. We should not forget that at the end of the day, for general populations as well as those groups with special needs, the issue of whether the CHC model is "worth" any extra cost involved is an issue of values as well as value.

Two caveats must be attached to the social equity rationale, however. First, considerable care will have to be exercised when designing funding mechanisms for health centres in order not to limit the role of centres to serving only high risk populations. Again, what is required is a flexible funding policy that allows funding levels and service models to be adjusted to the documented needs of identified groups. Some centres may have populations consisting almost entirely of high risk groups, while for others high risk subgroups may be a small part of an otherwise "average" practice population. Funding mechanisms should recognize this and allow services for the two to be funded differently.

Second, the need to close the system of fee-for-service and non-fee-for-service sectors cannot be overemphasized. Unless accountability (preferably to the consumer through incentives to patients to choose efficient practice styles which identify and meet their needs) can be established in both sectors simultaneously, the potential resource commitment is bounded only by arbitrary decisions on funding ceilings and ensuing confrontations with sector representatives. This is an especially important consideration for the social equity rationale, since nowhere in that rationale is the efficacy of the key elements of the community-based approach questioned. It is not transparent, and certainly not established, that health promotion strategies and health and human service coordination are efficacious interventions. If they are not, even the social equity rationale cannot justify them. How will program effectiveness be ensured unless patients are encouraged to reveal their assessments of value for money through informed choices, and providers are forced in reacting to these choices to look more closely at efficacy and effectiveness. In the absence of such assessments by the persons most qualified to make them, external evaluation of the cornerstones of the health centre approach takes on increased significance.

3. Policy Options and Recommendations

There would appear to be a limited set of funding options available to deal with the immediate question of how to fund the ten existing HC's once their current contracts expire. These options are described in the first sub-section, with conclusions and recommendations in the following one. In the third sub-section, the recommended funding policy within the ten existing centres is placed in the context of a proposal for programmatic funding across both the CHC spectrum and the fee-for-service sector.

3.1 Specific Options for Funding Within HC's

3.1.1 Continue the status quo of short-term contracts for "salary plus overhead" global budgets as an interim funding mechanism until the HC's become capitation viable. A continuation of the status quo is taken as unacceptable to both the HC's and the Ministry for the reasons discussed in sub-section 2.3. A variant of the status quo which might be worth considering, however, would involve some action on the part of the Ministry to remove the uncertainty and guarantee survival for the existing centres. This might be done through specific enabling legislation, or through Ministry regulations without enabling legislation. Neither of these seem promising, however, because they do not address issues of accountability, the appropriateness of "salary plus overhead globes" if capitation maturity is attained, or the future role of HC's in the primary care system.

3.1.2 Adopt "service globes" as an ongoing funding mechanism. This option accepts the fact that many HC's will not be viable on capitation because i) the patient population is too small, or ii) the patient population has a higher burden of illness than the average implied in the existing capitation rate, or iii) the existing capitation rate will not support the community-orientation to primary health care that some HC's operating at the right edge of the CHC Spectrum demonstrate. This strategy thus abandons capitation as a goal for all HC's and creates ongoing funding through the Program Development Branch based upon a global budget mechanism. But it does not employ the current global budget mechanism. The current mechanism is a "staff globe", i.e. the budget is based on an approved staff complement plus overhead allowance. Because this has always been seen as an interim measure meant to finance whatever staff complement had existed in the centres historically, until the centres could be moved to capitation, little attention has been paid to systematic justification of staff on a service basis.

Under the new option, global budgets would become "service globes". HC's would, in conjunction with Ministry staff, specify programs or services within the centre (the columns of Figure 1), set objectives for these programs, identify the populations served, and justify in program submissions the allocation of specific staff and overhead to each program or service. This funding arrangement would closely parallel what I understand to be the model for the highly successful Adult Community Mental Health Clinics. A manual to assist HC's with their program submissions would be developed which encouraged management by objectives within the centres and provided for accountability to the Ministry. Presumably the Association of Health Centres would play a leading role in the refinement of the "service globe" mechanism and might even assume an ongoing accreditation function on behalf of the Ministry.

Existing HC's would be required to initially convert their staff globes to service globes by providing the program description and documentation listed above. Once these had been approved, however, the budgets inmplied in them would become an ongoing operational base. Any requests for additional funds to augment existing services, or add new ones would require a new submission. It is not possible to sketch more than the skeleton of a service globe approach in this memorandum, yet one point must be emphasized. The process of refining an acceptable ongoing funding mechanism from this concept will require close collaboration between the Ministry and the HC's. A new posture of trust and compromise will have to be adopted by both groups.

Finally, it should be noted that the availability of an ongoing service globe option does not preclude HC's that want to go onto capitation from doing so. This is developed more fully in 3.3 below.

3.1.3 Link funding to other geographically defined entities, such as public health units, hospitals, or District Health Councils. This strategy would fold HC's global budgets into the existing funding mechanism for some larger, already established organization. This would be one way of accommodating many HC's articulated desire to serve a geographically defined population instead of a specific roster of signatures. It would also afford the potential for better accountability through established review mechanisms, though considerable effort would be required to work out the administrative detail. Unfortunately, DHC's are probably ill equipped to handle such an arrangement, and linkage of HC's to hospitals would likely retard their growth (due to their small power base in the institutional structure) unless payments for both primary and secondary care were somehow integrated. Moreover, it is highly unlikely that HC's would find either of these linkages acceptable in terms of their orientation, goals and tolerance for administrative encumberances. The orientation of public health units would be much closer to that of the HC's. Indeed, many HC's already work closely with their local units. Thus, if administrative integration could be accomplished, this may be an avenue worth pursuing further.

3.1.4 Continue to move to capitation, with redefinition of the capitation base. This strategy would seek out ways to redefine the basis for the capitation rate, in order to overcome past criticisms of it and possibly adapt it to a community-based, primary health care orientation. Redefinition could occur along two major conceptual avenues, in addition to the more technical revisions suggested in sub-section 2.2. First, with substantial research investment, a series of "weights" might be established to improve the sensitivity of the rate to population characteristics other than age and sex. The incidence and severity of illness, as reflected in health status, is the most important weighting factor, but also the most difficult to measure. Whether suitable proxies could be found (the correlate socio-economic status is often suggested) is an empirical (and open) question. In principle, other factors claimed to affect health needs and utilization could be researched and other weights could also be established.

While this avenue might improve the accuracy of a capitation rate based on service provision in a traditional primary medical care model, and thereby create a more equitable rate, it would still be considered inappropriate by those centres at the right edge of the CHC Spectrum. Equitable though it might be, the rate would still originate in a model of service provision from the opposite end of the spectrum and would likely not be sufficient to fund either comprehensive social service programs or illness prevention/health promotion programs. For these activities, a different view of the capitation rate would be required, one of a health capitation rate instead of a health care capitation rate. The determination of a health capitation rate would be inescapably arbitrary, given the dearth of data available for this task. Perhaps the simplest way would be to add an arbitrarily determined supplement to an equitable health care rate in order to allow for the broader orientation of the centres.

Unfortunately, even if redefinition along both of these avenues occurred, three problems would still remain. First, redefinition will take time. What mechanism will be used to fund HC's in the interim? The question is distressing familiar. Second, apparently for a significant portion of the potential population of some HC's the requirement of a roster signature will deter them from using the centre. Further, for many of those who do sign, the signature will not deter them from frequent use of other sources of care. In either event, the purpose of rostering is defeated. Finally, even if rostering is a complete success, there will always be some centres that are simply too small to operate effectively within any reasonable range of capitation payments.

3.2 Conclusion on Funding Options Within Health Centres

While the concept of a redefined capitation rate is worth exploring, the adoption of service-based global budgets appears to be the only feasible strategy for dealing with the main concerns of HC's while simultaneously improving HC accountability to the MInistry ---- and accomplishing both in the relevant policy horizon. It should be noted, however, that the alternative of linkage to public health units has not received a thorough review. It is also understood that adoption of service-based global budgets as an ongoing funding option should not preclude HC's from electing capitation funding at current or future levels of capitation payment.

3.3 A Proposal for Programmatic Funding Across the CHC Spectrum and the Fee-for-Service Sector

In this sub-section I shall attempt briefly to sketch for Task Force discussion the framework of a funding matrix for future policy development in primary health care that is consistent with both the general principles and specific recommendations of the memorandum.

The basic idea is that both fee-for-service providers and organizations on the CHC Spectrum should be able to access resources from three different funding pools, upon satisfaction of certain criteria. This is displayed in Figure 3. The rows of the matrix designate FFS providers (solo or group), HSO's and HC's as they are currently defined by the Ministry. The columns of the matrix designate three ongoing funding pools. The first, which already has the status of an ongoing program pool, is the fee-for-service funding pool. The second and third pools, capitation and CHC, would need to be more formally established as ongoing programs.

The expectation would be that each type of provider would draw most but not necessarily all of its funding from one pool, as shown by the X's on the diagonal of the matrix. However, if a provider or organization could meet appropriate criteria for entry into the other two pools, he (it) would be free to make application and receive funds via other than his (their, its) main funding mechanism. Thus, for example (and speculating freely!)

- an HSO might apply to the CHC pool for a service globe to support a health promotion program (of a type with previously documented efficacy) for a specified target group (e.g. seniors)

- an HC might declare a proportion of its population "average" and accept capitation for them, while staying on service globes for the

Figure 3 Flexible, Programmatic Funding Across the CHC Spectrum and the Fee-For-Service Sector

		FUNDING POOL		
		Fee-for-Service	Capitation Program	CHC Program
TYPE OF PROVIDER	FFS	X		
	HSO		X	
	HC			X

rest of its (specified) population

- HC's with high numbers of transients might work out acceptable arrangements for fees-for-service for such individuals

- a group of FFS providers might apply for a service globe to hire a nurse practitioner to provide health promotion or home care

- ultimately FFS providers might roster patients and become eligible for ACIP payments

A mixed funding approach would have obvious advantages for small HC's, or those with atypically high-risk populations, or those wishing to adopt a community-based approach to primary health care, since they would not be forced inappropriately onto capitation. Furthermore, scope is retained to work toward redefined capitation concepts, perhaps as an option instead of service globes from the CHC pool.

The essential elements of this system are sets of well-defined and reasonably interpreted criteria for access to each pool. These will require development that is beyond the scope of this memo. However, taking the CHC funding program as an example, it might be the case that to draw primary funding from this program a centre would have to meet all five CHC criteria at the right hand edge of Figure 2. To draw supplementary funding from this pool might require that the provider or organization be able to demonstrate objectives consistent with the CHC principles. For example, an HSO from the left edge of the CHC spectrum might not be required to create a community board in order to apply for health promotion staff; however, it might well be expected to demonstrate community involvement in the planning of (say) social service counselling for native people, if it sought funds for such a program supplement. Similarly, considerable thought would be required to specify criteria (and their range of reasonable interpretation) for the other two funding pools. However, this seems precisely the type of development needed if pluralism in funding is to be embraced in a manner which respects both needs of populations and characteristics of providers and organizations.

4. Further Issues

At this point one is reminded of the adage "To every complex problem, there is a simple answer......but it's wrong". The development of a funding policy to encourage the efficient provision of effective primary health care is a complex problem. Unavoidably, the analysis, short-term funding recommendations, and suggested long term framework presented in this memorandum are oversimplified. Critical review will surely raise a number of unaddressed or insufficiently addressed issues; however, I would like to briefly identify four such issues which I consider to be integral to any eventual solutions.

1. The existence of multiple funding sources for HC's poses problems of coordination and integration which I have abstracted from, especially in the immediately preceding sub-section. I have adopted a broad view of the phrase "primary health care", in keeping with the philosophy of the Task Force. It is important to recognize, however, that a significant proportion

of the funds for service globes envisioned in the CHC funding program currently originate or may have to be obtained from other Ministries. Whether aggressive leadership by the Ministry of Health can meld a variety of funding sources into an effectively focussed program is an open question. Yet it would appear that the Ministry of Health is the appropriate Ministry to take such a role, since the involvement of other funding sources is the direct result of movement along the CHC Spectrum.

2. The relationship of organizations on the CHC Spectrum to District Health Councils has received less attention in this memorandum than it deserves. Although a flowing of funds through DHC's may not be the answer to the immediate funding mechanism question for existing HC's, DHC's nevertheless will have an important role to play in future primary care developments. As the entity with the best vantage point for assessment of population health needs, DHC's would seem to be an appropriate mechanism for processing the establishment of new HC's or CHC's. Similarly, their consultation might prove valuable to existing HC's planning major program revisions or supplementary requests. Furthermore, although space precludes development here, it has been apparent from Task Force discussions that the relationship of DHC's and HSO's/HC's may be of necesssity different in Metro Toronto than in the rest of the province.

3. The attempt to clarify funding issues and alternatives has underlined the almost total inadequacy of existing data bases for policy development exercises such as this. Do HC's serve "sicker" populations than HSO's and FFS providers? What proportion of the HSO/HC patient populations are transients or ineligibles? What accounts for such transience or

ineligibility, and what does this imply for service programming? How does the full social cost of CHC provision of primary health care compare to that in the alternative of FFS medical plus fragmented social service provision? More important, how does health status compare? We simply do not know the full answers to these questions. Perhaps, however, our ignorance on these issues does not interfere with intelligent policy selection sufficiently to warrant extensive investment in answers to them. What is needed is a priorized agenda of potential research, targetted to the short and long term funding options discussed here. I would hope that the Task Force might either generate such an agenda or set in motion a process to do so.

4. Finally, the linkage of short-term funding solutions for HSO's/HC's to a deliberate strategy for longer-term management of the primary and secondary health care systems could itself occupy a separate memorandum. The flexible funding approach suggested here has attempted to avoid foreclosing options. The danger in this is that it tends to foster an open-ended system. One example from the preceding sections of the need to close the system is the requirement for accountability for hospitalization patterns in the fee-for-service sector in order to fully realize the savings from deinstitutionalization along the CHC spectrum. Another example is the question of evaluation of the hypotheses underlying the criteria for CHC's. If judgements on the production and receipt of value for money are to be made by trained practitioners and informed patients each with some direct financial stake in the outcome, then some form of contract with "lock-in" provisions or "bypass fees" will be necessary between providers and patients. Yet this is a controversial (and poorly understood) issue. If assessments of value for money across models of primary care provision are

not to be made in this manner, then by whom and how will they be made. Unfortunately, the current Task Force can do little more than flag this important issue of model linkage and system closure.

APPENDIX 'B'

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